COMPRESSED WORKWEEK FOR VA NURSES AND EXTENSION OF EXPIRING AUTHORITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES

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CONTENTS

March 17, 1982

Page

Compressed workweek for VA nurses and extension of expiring authorities 1

Statements by Committee Members

Chairman Mottl 1

Hon. John Paul Hammerschmidt 3

Witnesses

Corrada, Hon. Baltasar, Resident Commissioner of Puerto Rico 4

  Prepared statement of Commissioner Corrada 47

Custis, Dr. Donald L., Chief Medical Director, Veterans' Administration 14

  Prepared statement of Dr. Custis 53

Mansfield, Gordon H., associate legislative director, Paralyzed Veterans of America 32

  Prepared statement of Mr. Mansfield 63

Magill, James N., special assistant, National Legislative Service, Veterans of Foreign Wars 33

  Prepared statement of Mr. Magill 71

Egan, Paul S., deputy director, National Legislative Commission, The American Legion 34

  Prepared statement of Mr. Egan 74

Supplemental Material Submitted for the Record

Bills:

  H.R. 5737—To extend expiring authorities of the Veterans' Administration to make grants related to State nursing home facilities, exchange of medical information, and support of medical schools 41

  Draft bill—To amend title 38, United States Code, to authorize the Administrator of Veterans' Affairs to provide that Veterans' Administration nurses who work two 12-hour regularly scheduled tours of duty over a weekend shall be considered to have worked a full basic workweek 43

  Draft bill—To amend title 38, United States Code, to extend for 1 year the authority for the provision of Veterans' Administration health care by contract in the Commonwealth of Puerto Rico and in the Virgin Islands 46

Statement:

  De Lugo, Hon. Ron, a delegate in Congress from the Virgin Islands 84

COMPRESSED WORKWEEK FOR VA NURSES AND EXTENSION OF EXPIRING AUTHORITIES

WEDNESDAY, MARCH 17, 1982

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met, pursuant to notice at 9 a.m., in room 340, Cannon House Office Building, Hon. Ronald M. Mottl (chairman of the subcommittee) presiding.

Members present: Mottl, Hammerschmidt, Hillis, Solomon, Edgar, Albert Lee Smith, Christopher H. Smith, Applegate, Dorgan, McEwen, Boner, and Napier.

OPENING STATEMENT OF CHAIRMAN MOTTL

Mr. Mottl. Good morning. The Subcommittee on Hospitals and Health Care will come to order.

We are here for the purpose of hearing testimony on three legislative proposals. The first is H.R. 5737.

The first provision of the proposed bill would extend for 3 years the authority of the Administrator, under section 5033 of title 38, United States Code, to make grants to several States to assist in the construction of facilities for furnishing domiciliary, nursing home, or hospital care to veterans in State veterans' homes.

The current statute authorizes funding as necessary for this purpose, and will expire on September 30, 1982, unless it is extended. The subcommittee heard testimony on this proposal during the first session of the 97th Congress.

You may recall that it came to us as an administration proposal, H.R. 4025. Consequently, we have not asked the witnesses to address themselves to this issue this morning.

Second, the proposed legislation would extend the authority for the appropriation of funds for the Administrator to carry out a pilot program for the exchange of medical information.

Section 2 of H.R. 5737 would provide funding as necessary for this program in lieu of the present $4 million per year, and it would provide authority for the program for an additional 3 years, or until September 30, 1985.

Third, the bill would extend the authority for the appropriation of funds to the Veterans' Administration for the purpose of making grants to medical schools and schools of allied health which have maintained affiliations with VA hospitals.

H.R. 5737 would authorize the appropriation of such sums as may be necessary to make grants for this purpose and would extend the authority for 3 additional years.

We will also hear testimony on a legislative proposal to extend the Administrator's authority to contract for the inpatient and outpatient care of eligible veterans in Puerto Rico and the Virgin Islands under section 601(4)(C)(v) of title 38, United States Code.

In this regard, I would like to add that I have asked the Inspector General of the Veterans' Administration to look into the data presented in the "Report to Congress on Health Care for Veterans in Puerto Rico and the Virgin Islands."

This report was submitted on March 10, 1981, in response to a congressional mandate included in section 8 of Public Law 95-520.

The reason for my request to the Inspector General relates to my belief that the Congress must be satisfied that the seemingly high incidence of diagnoses of certain categories of disease and disability, specifically psychiatric conditions, is based on sound medical judgment by contract physicians.

For example, table 13 of the VA's report to the Congress relates that the current VA-operated medical and surgical beds, when combined with contract facilities, already exceed by 38 percent the number of such beds per 1,000 veterans in the VA system as a whole.

Further, this table shows that the number of psychiatric beds per 1,000 veterans in Puerto Rico and the Virgin Islands exceeds by 378 percent those in the VA system as a whole. The findings of the Inspector General's study, combined with the March 10, 1981 report, will be instrumental to our determining how we will provide Puerto Ricans and Virgin Islanders health care in the future.

The last proposal that we will hear testimony on this morning is one to amend title 38 to authorize the Administrator of the Veterans' Administration to provide a compressed workweek for registered nurses in the Department of Medicine and Surgery.

Specifically, this proposal would provide that registered nurses who are regularly scheduled to work two 12-hour tours of duty within the period beginning midnight Friday to midnight Sunday will be considered for all purposes to have worked a full, basic workweek.

In oversight hearings and visits to VA medical centers, the problem of recruitment and retention of registered nurses has consistently been brought to our attention, including the so-called Baylor Plan which does exactly what this proposed legislation purports to authorize for the Department of Medicine and Surgery.

We have heard testimony in our budget hearings that approximately 800 VA acute care beds are closed due to the inability to recruit nursing personnel.

We hope that this morning's testimony will give us specific guidance on the flexibility required in order to place the Department of Medicine and Surgery in a competitive position with the private sector regarding the recruitment and retention of nursing personnel.

Before we call our first witness, I would like to call on our ranking minority member, the Honorable John Paul Hammerschmidt, for any opening remarks he may care to make.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

The hearing today gives us an opportunity to hear testimony with respect to several important matters related to medical care of hospitals.

I'm particularly looking forward to the testimony of our colleague Mr. Baltasar Corrada, whom I'm sure will give us excellent insight into the question of extending contract authority for medical care for nonservice-connected disability in Puerto Rico and in the Virgin Islands.

Mr. Chairman, the report of the Veterans' Administration on this subject, which came to us last March is very specific as to unique needs of the veterans of these islands.

The proposal before us is only a stopgap measure concerned with the 1-year extension of current authority. It is my judgment that our subcommittee must also address the long-range situation in Puerto Rico and the Virgin Islands, and I hope the hearing will be helpful to us in that regard. I know that Ron de Lugo has just as mush interest in this as Baltasar Corrada does.

Mr. Chairman, we will also hear this morning about proposals to help solve the problem of recruitment and retention of nurses in the VA medical care system. This problem is acute in many areas of the country. We need to do all that we can to help the VA to solve it.

This aspect of our hearing is most timely and I'm grateful that we're focusing upon it.

I'm pleased to note, Mr. Chairman, that the Veterans' Administration is recommending extension of authority for grants to States for construction, remodeling or renovation of State homes for veterans.

In my opinion, this program is an excellent addition to the basic VA program and one that is not only vitally needed but one that is very cost effective.

With respect to extension of authority for appropriations for the exchange of medical information and extension of authority for VA grants to medical schools and other health related training institutions, I am told that VA has serious reservations, believing that these two programs have basically served their purpose.

In this connection, the Congressional Budget Office estimates that the exchange program authorization cost would be $1.7 million in fiscal year 1983 and that the grants program authorization cost would be $32.4 million.

While outlays are somewhat less for the initial year, it should be stated that there is no money in VA's 1983 proposed budget for these programs.

Mr. Chairman, the matters before us are most timely.

We look forward to hearing from our witnesses.

Thank you, Mr. Chairman.

Mr. MOTTL. Thank you very much, Mr. Hammerschmidt, for your excellent statement.

The delegate from the Virgin Islands, Ron de Lugo could not be with us this morning but he did submit an important statement that will be submitted into the record without objection.

Hearing no objection, it is so ordered.

[The statement of Hon. Ron de Lugo appears on p. 84.]

Mr. MOTTL. We have as our first witness, a good friend of mine and a good friend of the committee members here, the Honorable Baltasar Corrada, Resident Commissioner of Puerto Rico.

We want to welcome you this morning, Mr. Baltazar and we look forward to your statement and your entire statement will be submitted into the record without objection and you may proceed as you deem fit.

[The prepared statement of Hon. Baltasar Corrada appears on p. 47.]

Mr. MOTTL. I've had the pleasure of serving on the Education and Labor Committee for several years with Mr. Corrada and he makes a great contribution to the Congress through his legislative initiatives. I think the people of Puerto Rico should certainly be very proud of your record here in the House of Representatives.

At this time, I'd like to introduce to the subcommittee the Honorable Baltasar Corrada for his statement this morning.

STATEMENT OF HON. BALTASAR CORRADA, RESIDENT COMMISSIONER OF PUERTO RICO

Mr. CORRADA. Thank you, Mr. Chairman, for your kind words. I also want to express my appreciation to the remarks made by Congressman Hammerschmidt.

Mr. Chairman and members of the subcommittee, my name is Baltasar Corrada, Resident Commissioner from Puerto Rico to the U.S. Congress.

I have the privilege of being the sole representative of 3.4 million American citizens in that island of which, approximately 165,000 are veterans.

I wish to thank the members of this committee for giving me the opportunity to address the issue of medical assistance for veterans in Puerto Rico.

A historical note I wish to point out is that in March 1917, as the First World War raged in Europe, Congress bestowed U.S. citizenship to the residents of Puerto Rico by enacting the Jones Act.

During the First World War, 18,000 Puerto Ricans joined the Armed Forces and contributed to the U.S. victory in that conflict. I feel proud of our answer to the call of duty. We Puerto Ricans served without reluctance or reservation. We served gallantly and out of desire to prove our loyalty to the United States. As a matter of fact, more than 270,000 Puerto Ricans have served in the Armed Forces since 1917.

Our human contribution to this Nation goes far beyond any commensurable amount. One thousand twenty-five Puerto Ricans died and over 6,000 were wounded in the wars which our Nation has been involved in this century.

The deeds of Puerto Ricans in defense of our ideals of democracy were highlighted during the Korean War where 700 Puerto Ricans died and over 2,000 others suffered casualties, a rate that would rank us third among all States and Territories, in proportion to our population.

And, of course, four Puerto Ricans have received the Congressional Medal of Honor, all of them posthumously.

Mr. Chairman, it is a known fact that most veterans in Puerto Rico rely on the VA system for medical assistance and that their demand for care is higher than in any other place in the VA system.

In the VA's "Report to Congress on Health Care for Veterans in Puerto Rico and the Virgin Islands," four valid reasons are provided to explain this situation: One, the rates at which acute conditions occur are higher in Puerto Rico than in the U.S. mainland, indicating a somewhat poorer health status than for U.S. veterans in general; two, mental health problems occur at a higher rate in the case of veterans in Puerto Rico than in the VA system as a whole; three, the average Puerto Rican veteran cannot afford fee-for-service care; four, the quantity of public health services provided by the Puerto Rican government are inadequate in relation to need.

I may add that a major factor contributing to the last of these causes is that medicaid applies in Puerto Rico on a very limited basis with the Federal Government providing only $45 million, while the Puerto Rican government provides over $120 million.

Thirty-four percent of our veterans in Puerto Rico come from families with an income below $7,000; 42 percent from families with an income between $7,000 to $14,000. So, this clearly shows that over 70 percent of our veterans come from low-income families. And only 24 percent come from families with incomes over $15,000.

Even though the Puerto Rican government has annually increased its budget for health care services facilities, inflation brought about an actual decrease in buying power. Puerto Rico's financial condition precludes a massive investment in funds in this area and, therefore, no major improvements in the health care system can be made on a short-term basis.

Currently, in the non-VA sector of health care, there are fewer beds per 1,000 inhabitants in Puerto Rico than in the U.S. mainland, which of course, is one of the reasons why there is a larger demand for veterans in Puerto Rico to go to veteran facilities than their counterparts in the U.S. mainland.

The quality of care provided and the adequacy of the medical facilities in Puerto Rico, even though significantly improved over the years, are still substantially below that provided at the Veterans' Administration Medical Center in San Juan.

Consequently, the VA medical center in San Juan has consistently received the largest number of applications for hospitization in the entire VA system. It is ranked sixth in the Nation in number of staff visits and fourth in the number of medical visits.

In fiscal year 1981 this center attended 257,986 staff visits and 81,619 fee visits. The walk-in applicant in our VA medical center and the Mayaguez Clinic are over 300 a day. The VA hospital in San Juan operates at full capacity with an occupancy rate of close to 90 percent throughout the entire year.

The high demand for medical assistance by veterans in Puerto Rico overwhelms the capabilities of the VA's limited facilities on the island which also services the veterans of the Virgin Islands.

Contracting and fee for service have become the method for providing medical services to many veterans on these islands. The contract hospitalization program in Puerto Rico and the Virgin Islands, which dates back to the Roosevelt administration and was the only source of VA hospitalization until 1946, has been closely monitored over the years.

In 1948, Mr. Chairman, there were 32 private hospitals under contract with the VA in Puerto Rico which handled an average patient load of over 1,100 veterans. In recent years, only seven hospitals remained under contract and the patient load has been reduced to 609.

A new plan to further reduce the number of patients in contract hospitals has been in effect since the latter part of fiscal year 1981. And as of January 30, 1982, the average number of patients in the hospitals was down to 468.

Let me point out that the patient reduction program is a result of budget constraints faced by the contracting-out program and not due to a decrease in the number of veterans in need for the health care services in Puerto Rico. This program received $1.1 million less for fiscal year 1982 than its allocation for fiscal year 1981.

It is my understanding that the Veterans' Administration, to avoid compromising in the quality of its health care services, has forcefully increased the rejection rate of needy veterans on the island.

The record shows that the VA has been highly selective in accepting applicants for medical assistance in Puerto Rico. For many years, the VA in Puerto Rico held the highest rejection rate in the system. Nevertheless, contracting-out medical services in Puerto Rico is still the only way for the VA, with its limited facilities, to give adequate medical attention to all those veterans in need of care in the islands.

Mr. Chairman, I urge this subcommittee to support the authorization to extend the flexibility granted to the VA to contract out medical services for nonservice-connected patients in Puerto Rico and the Virgin Islands until a new program is implemented to take care of the long-term needs of our veterans on these islands.

I believe, by the way, Mr. Chairman, and I wish to address this issue, that the time is right for us to consider the options presented by the Veterans' Administration in its report to Congress on February 1, 1980, of how to solve the inadequacies of the VA system on the island, and I hope that in the 5-year plan this issue is addressed by the Veterans' Administration.

I particularly support the alternative of building a new wing in the VA Hospital Center in San Juan to house all VA's psychiatric patients and closing of all psychiatric beds in contract hospitals when the additional facilities are available.

Mental illness is the No. 1 health care problem in Puerto Rico. We have 1,108 veterans in Puerto Rico who have not been able to recover from the traumas caused by the horrors of war suffered at the expense of our security and freedom.

There are also many more nonservice-connected veterans with mental disorders lacking proper medical attention. Currently, the VA can only house 240 psychiatric patients and contract out for an additional 564 veterans in facilities not comparable in quality of care to the VA's facilities.

One way that we could save money in the operation of this program, Mr. Chairman and members of the subcommittee, is by providing the services directly by the VA.

Let me point out that the average length of stay in the VA's facilities on the island is 22 days. Whereas, in contract hospitals, it averages over 90 days, a matter that is of great concern to me.

A new wing for psychiatric beds, particularly, could bring together with the advanced services utilized by the VA's medical staff for efficiently handling psychiatric cases and adequate facilities to house these services. I am confident this arrangement will prove to be more efficient and less costly to the administration and beneficial to our veterans.

Mr. Chairman, for those who ask the question, and it is a valid question, as to why is it that psychiatric care for veterans in Puerto Rico is in much higher demand than any place in the mainland, I would like to advance three answers in addition to some of the points I have already mentioned.

First of all, one must take into consideration the population density of the island of Puerto Rico. We have a density of 940 persons per square mile. If you placed in the 50 States in the U.S. mainland, the population of the entire world—if we brought to the U.S. mainland all the people in China, all the people in India, all the people from Africa, from Latin America, from Europe, from the Soviet Union and placed them here, in the U.S. mainland, we would have a population density slightly over 1,000 persons per square mile.

Well, Puerto Rico has now a population density of 940 persons per square mile.

May I ask you, Mr. Chairman, would that not reflect on the mental health problems of the American population? If we brought the people from the entire world and placed them here in this Nation, would that not pose a very serious problem in terms of the mental health difficulties that our people would face?

These are the difficulties that veterans in Puerto Rico face with that kind of population density and I venture to say that that population density is definitely a reason why mental health problems of veterans in the islands is higher than the U.S. mainland, where the population density right now is only 61 persons per square mile.

Second, the poverty question: Seventy percent of the entire population of Puerto Rico is under the Federal poverty level. Seventy percent of the veterans in Puerto Rico are of low income and there is no question that economic deprivation is an additional stress in the lives of people and in the lives of veterans in Puerto Rico that does not exist to that extent here in the mainland and another reason and cause of higher incidence of mental health problems.

The third element is one that is, I would say, peculiar to the veterans of Puerto Rico. All war veterans have to cope with the tremendous stresses of being involved in the war. Just as the veterans from Puerto Rico, being as they are, American citizens.

But in their case, there is an additional stress, the language barrier. These veterans come from an island where Spanish is our vernacular. They are drafted or volunteered to go to the armed service of the United States. Let me say by the way, that they have always volunteered significantly to serve in the Armed Forces of the United States.

But then, they face the language problem, the language difficulties in the environment. Perhaps, I ought to tell you a joke that I have heard among veterans in Puerto Rico and perhaps I can tell it, because I am a Puerto Rican. Maybe you couldn't tell it. Maybe somebody who is Irish here, he could make an Irish joke. Someone of Polish ancestry, he could tell a joke about Poles. Well, I'm a Puerto Rican and I can tell a joke on Puerto Ricans.

There were these Puerto Rican veterans, together with four or five U.S. mainland veterans in the Korean war. And they were in a platoon. One of the U.S. mainland soldiers saw a Korean with a rifle that was approaching them. And this U.S. mainland soldier yelled, duck, and everybody hit the ground and the Puerto Rican soldier stood up and says, "Where's the duck?"

Well, that's a silly joke told among veterans in Puerto Rico, but I can assure you that the stress of being in the war, having language limitations as most of our veterans do have, is an additional stress that reflects in the incidence of mental health problems in some of these veterans in Puerto Rico.

But I can tell you that all of them are very proud that they serve. Puerto Rico always filled the quotas that we had, not only under the draft but in the volunteer army and they have felt proud that they have served the Nation gallantly and they will continue to do so, any time we have to defend democracy at home and abroad.

I urge the committee to extend the authorization. I also urge the committee to look into the longer range problem and as to how to address this situation, so that the Veterans' Administration does not have to be contracting out these services but perhaps providing them in-house on a long-term basis.

Thank you, Mr. Chairman.

Mr. MOTTL. Thank you, Mr. Corrada, for your excellent statement. You did address yourself to the concerns that I have about the psychiatric service connected problems of the veterans in Puerto Rico.

You stated at the conclusion of your prepared statement, that you thought that there were three reasons for the unusual psychiatric problems of Puerto Rico.

One, was the density of the population. Second was the poverty, and third was the language barrier—communication.

I still don't see the relevancy of why that would contribute to service-connected psychiatric problems. If they're having psychiatric problems, was that possibly before they got up to the service or after? Why would it necessarily have to be service-connected? That's the difficulty I still have.

Why would the incidence be 378 percent higher in Puerto Rico than elsewhere in the United States?

Service-connection, that's what I have——

Mr. **Corrada**. Well, again, there may be latent conditions, resulting from stresses of this high population density and poverty that, under ordinary normal non-war environments do not manifest themselves clearly; but under the stresses of a war environment, do manifest and express themselves more clearly.

I'm not a psychiatrist, Mr. Chairman, but I think that from plain commonsense and observation of the case histories that I have examined, and many of them write to me often, as part of my casework responsibility. And, you know, seeing some of the case histories that I have seen, I believe that this is an element that doesn't answer all the questions. But it is an element that is there.

Mr. **Mottl**. Thank you, Mr. Corrada. I just have two more questions, then I'll recognize any other members of the subcommittee for any questions they may like to proffer.

On page 3 of your statement, Mr. Corrada, you make a reference to the quality of care provided in medical facilities being substantially below that provided by the Veterans' Administration.

If additional psychiatric beds were to be constructed by the VA, how could these beds be adequately staffed, both quantitatively and qualitatively?

Mr. **Corrada**. I think that there is, of course, a talent of psychiatrists, psychologists, paramedical, and other type of personnel in Puerto Rico that could be recruited in terms of the cream of the crop. That may exist and do exist in some of the private psychiatric hospitals in Puerto Rico.

The problem there is, they have some good psychiatrists, psychologists, and so on, but not all of them are up to par in terms of the excellence that we find in the Veterans Medical Center.

But they could recruit again, the best out there in the island, and they could be trained properly through VA techniques in handling and dealing with the specialized psychiatric problems of veterans, where obviously the VA has a greater medical expertise and I am confident that should the additional beds be provided they could be adequately staffed.

But, Mr. Chairman, perhaps that question might be more appropriately addressed to a medical director of the VA.

Mr. **Mottl**. My last question, would you care to comment on the quality of outpatient and inpatient care Puerto Rican veterans receive on the contract basis now?

Mr. **Corrada**. I am concerned about it. I believe that the quality of services provided on a contract basis are below the standards of health care service provided to veterans by the VA Medical Center in San Juan. That is a cause of frequent complaint on the part of veterans that I referred to other—contract to other facilities.

This is why, although on a short-term basis, I am supporting the extension of this authorization simply because on a short-term basis there is no other immediate solution to the problem.

I think that it is important that we address the question of how these services can be provided directly by the VA and second, how, through administrative and managerial procedures, the need for contracting out could be limited.

Mr. **Mottl**. Thank you very much, Mr. Corrada.

Since we have good attendance here this morning, we'll invoke the 5-minute rule. We'll go around as often as necessary so everybody will have adequate time to ask all the questions that I would like to address to the witness.

First of all, I recognize the gentleman from Indiana, Mr. Hillis, do you have any questions?

Mr. **Hillis**. Thank you, Mr. Chairman.

I first want to begin by congratulating my colleague on his excellent statement.

Certainly in addition to your strong statement of an extension to contract authority in Puerto Rico and the Virgin Islands, you gave us a good explanation of the history of the people there with regard to the contribution they've made in our joint defense, the defense of our freedom.

I certainly appreciate that. It seems to me as I listened to the questions Mr. Chairman, and your response on this staffing, that I would be correct in assuming that with the economic situation in Puerto Rico, salaries offered in the fields of health care in the Veterans' Administration facility, would be adequate enough to attract, probably, some of your better people to come in and staff a VA hospital.

Wouldn't these jobs probably be sought after?

Mr. **Corrada**. Definitely, they would rate much better than comparable salaries at the State government and local government levels. And I venture to say in most cases, they would also compare favorably with private psychiatric hospitals as well.

Mr. **Hillis**. As far as your medical people are concerned, am I correct in my memory, that a graduate there in medicine is required to give two years of public service, and if he went with the Veterans' Administration, this would not be necessary.

In other words, it would be a tradeoff, and for that reason, might be attractive to medical graduates?

Mr. **Corrada**. That is correct.

Mr. **Hillis**. Thank you. That's all.

Mr. **Mottl**. Thank you very much, Mr. Hillis.

The gentleman from Ohio, Mr. Applegate.

Mr. **Applegate**. Thank you, Mr. Chairman.

I want to compliment my friend and colleague for a very strong and very articulate statement. I don't have any questions except to comment that I do know that—and why. And I think you may have explained at least in part, why the rate exceeds in Puerto Rico and Virgin Islands, the rate exceeds that of the overall average as a whole.

But I'm hopeful that the committee, in its wisdom, will be able to work out some kind of a program that will be beneficial to the people of Puerto Rico and the Virgin Islands.

Thanks.

Mr. **Mottl**. Thank you very much, Mr. Applegate.

The gentleman from New York, Mr. Solomon.

Mr. **Solomon**. Mr. Chairman, I don't have any questions but I want to commend the gentleman from Puerto Rico, too.

I happened to serve in the U.S. Marine Corps during the Korean war with many Puerto Ricans, both draftees and volunteers. I number many of them among my closest friends, even today, and they made damn good Marines.

Thanks for your testimony.

Mr. MOTTL. Thank you very much, Mr. Solomon.

The gentleman from Tennessee, Mr. Boner?

Mr. BONER. Mr. Chairman, I have no comment other than to say that I appreciate the gentleman from Puerto Rico's comments and the statements that he has made and I'm sure that we will accept those and try to work to remedy some of the problems.

Mr. MOTTL. Thank you, Mr. Boner.

The gentleman from New Jersey, Mr. Smith?

Mr. CHRIS SMITH. Thank you, Mr. Chairman.

I have a couple of questions. I came in a little bit late and I do apologize for that. And perhaps, this was covered but how much would the new wing to the San Juan VA Hospital cost? Are there estimates on that?

Mr. CORRADA. In the report mentioned by the chairman. The report to Congress on the health care for veterans in Puerto Rico and the Virgin Islands, in response to Public Law 95-520, dated February 1, 1980,[1] although not received, by the way, until March 1981.

There are five options in this cost, Congressman, and they begin on page 43. They address the different options and possible costs for the different options.

Of course, these figures, as you know, change. Cost figures change as time goes on. Let me—I don't recall, offhand, Congressman, the specific——

Mr. CHRIS SMITH. But it's contained in that report, so we can look at it.

Mr. MOTTL. It's in the report that you're submitting.

Mr. CORRADA. This is an excellent report, and there are different options addressed. They give the cost elements. Definitely, of course, there would be an initial investment for providing these additional psychiatric beds in Puerto Rico.

But as I pointed out in my testimony, the average stay of a psychiatric veteran in Puerto Rico in the VA system is 22 days versus 90 days in the contracting out. So, when you analyze the cost benefit factors on the long-term basis, I think that investment will be amply returned.

Mr. CHRIS SMITH. You just anticipated my second question in part. And that was why the difference between the two, when you're talking 564 veterans who are in the 90 days are over?

Mr. CORRADA. In the report there, there's an issue. But essentially the answer is, the VA knows much better and has a greater expertise in how to handle veterans with psychiatric problems. As may do a general psychiatric hospital with veterans and nonveterans and with staff that is not specialized in handling psychiatric patients.

Mr. CHRIS SMITH. Has the VA made an attempt to try to share those insights that they've gained with the contract-out psychiatric centers?

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[1] See Committee on Veterans Affairs' Committee Print No. 22, "Health Care for Veterans in Puerto Rico and the Virgin Islands."

Mr. **Corrada**. Yes.

Mr. **Smith**. Because 90 days versus 22 days, when you're talking about the veterans' health, is a very large difference.

Mr. **Corrada**. Let me say that while I accept—the reason that I indicated as valid as an element—why it would take longer to treat a veteran in a private hospital than a VA hospital. I frankly believe that there must be more to it than just that.

And I don't want to conjecture but unquestionably when you have a contract with a supplier, you always believe that the supplier wouldn't mind keeping the need to supply the services. While I am sure that the Veterans' Administration monitors these programs carefully, as I indicated in my testimony, the contracting out has come down from 1,100 veterans a number of years ago, to over 600 this time.

I think that there must be room for improvement in that situation. I just can't understand why a veteran with a mental problem can be taken care of in 22 days in the VA hospital and it would take 90 days in the private hospital.

I am concerned about that. And I have some questions that I cannot answer in my mind as to why that is a situation.

Mr. **Smith**. One last question. The veterans that go to the VA with a 22-day average stay—how are they picked? Is it based on space availability?

Mr. **Corrada**. Well, of course, the service-connected have——

Mr. **Smith**. Right. The normal apparatus takes over.

Mr. **Corrada**. Preference. But even some service-connected are referred. And I presume the Veterans' Administration has some reason as to some procedures on how to refer or how to determine that they take the case.

In some instances, it relates to past history whether these have been patients that already have a record in the Veterans' Administration versus a record on the other private facility.

But I am not aware and perhaps that would be a question that you would want to ask to the medical director there.

Mr. **Chris Smith**. OK, thank you. Thank you for your statement.

Mr. **Mottl**. Thank you very much, Mr. Smith.

The gentleman from North Dakota, Mr. Dorgan, do you have any questions of the witness?

Mr. **Dorgan**. No.

Mr. **Mottl**. Thank you very much, Mr. Dorgan.

The gentleman from Alabama, Mr. Smith.

Mr. **Albert Smith**. Yes, Mr. Chairman.

Could you please, sir, do you have any idea of those who have stayed in VA hospitals as compared to those who stay in contract hospitals. Do you have any statistics of those who have been in the VA hospital with mental illness, having to go back with the average stay of 22 days as compared to those who stayed in contract hospitals having to return for further treatment?

Mr. **Corrada**. No; I don't have those figures available, Mr. Smith. The 240 psychiatric beds that the VA has directly, in fiscal year 1981, there were a total admission of 3,215. Of these, 17.5 percent were service connected and 29.5 percent were nonservice connected. In the case of those contracted out, total admissions were

12,719 of which 19 percent were service connected and 81 percent were nonservice connected.

Of course, as you know, the contracting-out authority is for the nonservice connected. That's why, obviously, there has to be a much higher incidence in terms of the nonservice connected going to the contracts.

Mr. ALBERT SMITH. The question, of course, that I'm driving at is are there some being released from the VA hospital because of the lack of space prior to their having really been cured and then later having to return for further treatment?

I'm trying to find some way to justify, and your answer may be the best answer that when you're paid on a contract basis for the number of days, bed days, then there might be a strong pull to extend the length of stay. That might be otherwise in the VA hospital.

I was trying to see if there was any correlation?

Mr. CORRADA. There might be, but I really don't know. I cannot tell you from the standpoint of direct knowledge of records there as to repeated hospitalization of mental patients. I would just be speculating if I gave you a number.

Mr. ALBERT SMITH. Let me ask another question. I'm trying to learn. You may not have the answer.

When the VA contracts out for these beds, they contract out with the hospital and then the hospital has on staff, positions, psychiatrists—independent operators.

They, of course, have an obligation not—in providing a service, I would think—not to extend the stay any longer than is necessary and this is reviewed by other VA physicians as to the length of stay, peer review on patients.

Mr. CORRADA. That is correct.

Mr. ALBERT SMITH. This is why I, too, like Congressman Smith of New Jersey, wonder about the great variance between 22 days and 90 days. It is hard to understand that there is so much difference. More than four times the difference, and I don't know if it's possible, Mr. Chairman, but could the VA find out if this is true across the country in contracting out and what causes this difference? Will VA address that?

Mr. CORRADA. Well, contracting out, of course, is much more limited on the mainland. These are special authorizations for Puerto Rico and the Virgin Islands. So, I presume there must be some technical services that might be contracted out.

But, I think also if I may suggest that the question in addition to comparing with experience in the U.S. mainland, VA direct versus contracting out, that possibly the medical director of the VA in Puerto Rico as well as the medical director of the VA here, would or should, address that issue.

They may have some explanations or they may find themselves in a difficulty to explain why this is the situation.

But it's one. While I suggest expanding this authority, because simply it would be a disaster if you didn't, that we must address the long-term issue and face the issue really and find a more efficient solution to it.

Mr. ALBERT SMITH. Thank you.

Mr. MOTTL. Thank you very much, Mr. Corrada. Thank you for appearing here.

Mr. CORRADA. Thank you all very much.

Mr. MOTTL. Next, we'll have Dr. Donald L. Custis, Chief Medical Director, Veterans' Administration, and some of his colleagues will be our next witnesses.

Dr. Custis, for the record, if you would introduce your colleagues at the witness table with you, accompanying you here this morning and your entire statement will be submitted into the record without objection.

I would like to say, just as one member and also as chairman of this subcommittee, the longer I know of your work, I think you do an outstanding job in behalf of the veterans of America and I just hope that you'll continue to have that same dedication and hard work that have been your trademark in the past.

Without further ado, I'd like to introduce you at this time. Dr. Custis, you may proceed as you deem fit in delivering your statement or you can summarize it.

STATEMENT OF DR. DONALD L. CUSTIS, CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION

Dr. CUSTIS. Thank you, Mr. Chairman. It's always a pleasure to be here. I, in turn, would like to introduce, on my right, Ms. Vernice Ferguson, who is the head of our nursing service and a deputy ACMD for professional services. Ms. Midge Quandt, the Assistant Chief Medical Director for Administrative Affairs, and Mr. Audley Hendricks, from our general counsel.

I do have an abbreviated statement extracted from the longer statement for the record.

We're again pleased to be here to testify on proposals to extend certain expiring authorizations and on a new initiative to authorize the administrator to approve flexible hours or a compressed work schedule for VA registered nurses.

Section 1, of H.R. 5737, would extend for 3 years the authorization for appropriations for grants to States for the construction, remodeling, or renovation of State home facilities.

As you know, Mr. Chairman, we testified last September before this committee in support of this position. I might say, parenthetically, as we get closer to that impact of the aging veteran population, we appreciate more and more, how the veteran will be very dependent upon these State homes for assistance.

We are submitting to the Speaker of the House today, an offer for your favorable consideration, a new draft bill that incorporates the provisions of H.R. 4025, as well as new initatives to further strengthen this State home program.

Section 2 of H.R. 5737, would extend for an additional 3 years, the authorization for appropriations for exchange of medical information grants. This is an authorization to fund pilot programs through grants to facilitate the exchange of medical information between VA facilities and other medical institutions.

The exchange of medical information authority, of which grants are just a part was intended to help cultivate an environment of academic medicine in VA hospitals. Especially, those in remote areas. The grants were used for such purposes as the employment of personnel, construction of facilities, and the purchase of equipment to develop and carry out medical information programs. The exchange of medical information program has been successful in the past in helping to create academic links between relatively remote VA hospitals and major medical centers.

But now, 15 years after it's start, the pilot grant program has essentially accomplished its purposes. The expiration of this grant authority does not deprive the VA of the authority to enter into agreements to share medical information.

It should be understood that our exchange of medical information program to date has been geared almost exclusively to the establishment of grant funded projects. Under section 5054 of title 38, we have broad authority, separate and apart from the grant authorization by which VA medical centers could initiate agreements locally to share educational and informational resources.

Just as we share specialized medical resources. So, our challenge is to apply that authority and develop agreements for exchange of medical information services with the surrounding medical community where beneficial.

This can be done without extending the grant authority. H.R. 5737, would also extend for 3 years the authorizations of appropriations for grants to VA affiliated medical schools and other manpower training institutions.

We view this program, also, as having largely served its purpose. While the program has been beneficial, the need has diminished and additional funding cannot be reconciled with more pressing mandates.

In essence, our priority must be on providing quality medical care to eligible veterans. As regards contract care in Puerto Rico.

Mr. Chairman, you have introduced legislation to extend for 1 year the VA specific contract authority to provide hospital and outpatient care for veterans in Puerto Rico and the Virgin Islands.

Public Law 95-520 extended the authority to provide this care until December 31, 1981. And also, required that the VA conduct and submit to the Congress and the President, a report assessing the health care of veterans in Puerto Rico and the Virgin Islands with recommendations on how those needs should be addressed.

This report was submitted to the Congress on March 10, 1981. We recognize that Congress may not have had the time to evaluate the entire issue including our report and recommendations. And we considered it to be prudent that this authority be extended for an additional year rather than risk either the expiration of this authority, without the provision of an alternative means of medical care for these veterans or the hasty enactment of legislation which may not be the most appropriate.

So, we support this bill. The extension of this authority until September 30, 1983, will result in an estimated cost to the VA of approximately $8.8 million.

Mr. Chairman, I would next like to discuss the recruitment and retention of registered nurses. The provision of Public Law 96-330, the VA Health Care Amendments of 1980, provided the Department of Medicine and Surgery the ability to recruit and retain registered nurses through the establishment and use of localized salary rates which are competitive with those paid by the competing hospitals and health care facilities.

These flexibilities, together with the changes occurring in the economy as a whole have made the VA more attractive as an employer.

Although a number of facilities continue to experience in recruiting and retaining RN's, this is typically a function of difficulty in recruiting and retaining RN's due to the local labor market not being sufficient to meet the requirements of the entire community.

Also, competition is beginning to occur in nonmonetary areas that improve the quality of both working and nonworking life. And which make one employer more desirable than another.

I believe under section 4107 of title 38 that the Department has established essentially a compressed work week. For example, 4 consecutive days work of 10 days per week instead of 5 of 8 hours, with the consent of the individually affected nurse.

In addition, Public Law 95-390, expiring this month was the basis used for experimental compressed work schedules at three locations within the Department. The positive experience in these experiments indicates that compressed workweeks have significant potential for mitigating recruitment and retention problems with nurses.

We can, I believe, expect to see recruitment and retention features improving as these dual authorities have had their full effect on the system.

There are other alternatives we are considering to meet the competition for nurses in specific locations. We feel that the so-called Baylor plan workweek as well as other alternatives should be studied by our nursing task force that was created to review nurse recruitment and retention problems as directed by Public Law 96-330.

We recognize the challenge to be met concerning the use of the alternative work schedules and compressed workweeks. However, we do not favor the enactment of a structured, defined program such as the Baylor plan.

That concludes the abbreviated statement, Mr. Chairman. We'd be happy to accept questions.

[The prepared statement of Dr. Custis appears on p. 53.]

Mr. MOTTL. Dr. Custis, thank you for your excellent statement this morning. And we'll have some questions, if we may proffer them to you at this time.

Dr. Custis, I made reference in my opening statement to the VA and contract vets for mental disorders in Puerto Rico being 378 percent greater per 1,000 veterans than in the VA medical facilities as a whole.

Could you give us the number of Puerto Rican veterans who are service connected for psychiatric conditions and tell us how this number compares to the continental United States?

Dr. CUSTIS. I'd have to provide that for the record, Mr. Chairman. I don't have those figures in mind.

[Subsequently the Veterans' Administration provided the following information:]

There are 7,734 veterans in Puerto Rico and the Virgin Islands who have a service-connected rating for psychiatric conditions. This represents 4.4 percent of the total veteran population indigenous to this area. By comparison, within the continental United States there are 331,080 veterans who have a service-connected rating for psychiatric conditions—and this figure represents 1.1 percent of the total veteran population within the continental United States.

Mr. Mottl. Is there an explanation for the incidence of mental disorders being so much greater in Puerto Rico than the continental United States? Are the rating examinations accomplished by fee basis exam as opposed to the VA rating examination. Could you give us the percentage of those accomplished on a fee basis, please?

Dr. Custis. That, too, we would provide for the record.

[Subsequently the Veterans' Administration provided the following information:]

During fiscal year 1981 there were 6,916 Compensation and Pension examinations performed; 6,351 examinations were completed in-house and 565 (or 8.2 percent of the total C&P exams) were completed on a fee basis.

Dr. Custis. I might say that in recent months, we've had the same concern and this has been the subject of review by inspection teams from DBV. We, as yet, are not completely satisifed as to the methodology of establishing that rating in Puerto Rico.

Mr. Mottl. This causes the chairman great concern and I'd certainly appreciate having immediate attention on this problem.

Would you give us a breakdown on the number of service-connected veterans receiving inpatient care on a contract basis in Puerto Rico?

Are all of these mental patients and can you tell us what the cost of this care is to the VA on a per annum basis?

Ms. Quandt. Could we supply that for the record? The majority of contract bids are for psychiatric care.

[Subsequently the Veterans' Administration provided the following information:]

In fiscal year 1981 there was a total of 3,689 patients who received contract inpatient care in San Juan and the Virgin Islands at an average per diem of $62.49. 457 (or 12.4 percent) of these were service connected veterans and 3,322 (or 87.6 percent) were nonservice connected. The majority were mental patients. The cost of this care in fiscal year 1981 was $13,571,811.

The following data reflects the four previous fiscal years comparing Puerto Rico to the Continental United States:

Fiscal Year	Total cost	Census	Per diem
Puerto Rico-Virgin Islands:			
1977	$9,641,000	608	43.48
1978	11,028,000	656	46.07
1979	11,204,000	541	56.73
1980	11,385,000	561	55.48
United States:			
1977	$27,139,000	430	172.92
1978	31,947,000	462	189.18
1979	30,735,000	371	227.03
1980	31,676,000	376	229.88

The lower per diem for Puerto Rico-Virgin Islands reflects the high percentage (92 percent) of psychiatric admissions.

Mr. Mottl. Service-connected?

Ms. Quandt. Non-service-connected.

Mr. MOTTL. What is the number of veterans receiving outpatient care on a fee or contract basis in Puerto Rico, together with the number that are service connected and nonservice connected?

Could we have the per annum costs of that for the VA?

Ms. QUANDT. I can give you the number of fee visits versus staff visits. I do not have statistics right now on service connected and nonservice connected. That we'll supply for the record.

[Subsequently the Veterans' Administration provided the following information:]

In fiscal year 1979 there were 74,823 outpatient fee visits at a cost of $2,661,063. In fiscal year 1980 there were 87,326 fee visits at a cost of $2,804,202. In fiscal year 1981 there were 75,567 fee visits at a cost of $2,448,048.

Type of Care	Puerto Rico and Virgin Islands	VA system
Rate per 1,000 veterans:		
Staff	1,106.9	526.6
Fee	437.6	70.0
Percentage service connected:		
Staff	57.5	44.2
Fee	50.3	71.1

When one looks at psychiatric outpatient load treated in house (excluding C&P and prescription refills), the rates are:

	Service-connected	Non-service-connected
San Juan	66	34
VA—Total	51	49

Ms. QUANDT. In the past, medical visits were 243,057. Fee visits were 77,000——

Mr. MOTTL. Could you use the microphone there so we can get this?

Ms. QUANDT. Staff visits were in fiscal year 1981, 243,057. Fee visits were 77,461. I can break out for you the visits, the staff and 73,387 were for service-connected condition; 54,909 were for a nonservice-connected condition.

The balance of those staff visits dealt with 6,516 for compensation and pension exam, 48,232 for exams for medical care. And on that one figure, we do not break it out as to service-connected, nonservice-connected.

Mr. MOTTL. Dr. Custis, could you give us your assessment of the quality of medical care that veterans are receiving, both inpatient and outpatient on a contract or fee basis in Puerto Rico?

Is this comparable to that provided in the United States?

Dr. CUSTIS. Mr. Chairman, the study that was completed and submitted to Congress a year ago, went into this in some depth. It was very specific in rendering the opinion that of the quality of care provided on a fee basis did not match that provided by VA personnel.

I have no firsthand knowledge of this. However, I would like to state that a small group of us having responsibility for firsthand review of the overall situation in Puerto Rico intend to make a visit to Puerto Rico in the near future.

Mr. Mottl. In the case of mental patients, is this including therapy or is this merely providing room and board?

Ms. Quandt. Our contract requires therapy.

Mr. Mottl. Do you receive the therapy then?

Ms. Quandt. Mr. Chairman, my answer is a rather subjective one from having been in Puerto Rico 2 years ago. The quality of the Puerto Rican hospital compared with a Federal hospital, meaning the VA hospital, the difference is very stark.

We have had complaints from some veteran service organizations that essentially the type of care we receive in the psychiatric facilities is that of a prison. The quality of life for the patient is not the same as in our hospital. The quality of care per visit would leave much to be desired.

Mr. Mottl. Thank you. If I could have the indulgence of the subcommittee for just two more questions here. I want to pursue this a little further.

Have there been problems in the past of the VA being overcharged by contract hospitals for care provided to the veterans?

Ms. Quandt. Yes, there have.

Mr. Mottl. Would you provide us the details and tell us what has been done about it?

Ms. Quandt. Yes.

Mr. Mottl. Provide that for the record? You don't have that information now then?

Ms. Quandt. No, sir. We would have to trace it back to 1974 to——

[Subsequently the Veterans' Administration provided the following information:]

A memorandum dated May 5, 1980, from the Director of our Northeast Region and sent to the Associate Deputy Chief Medical Director deals with the Regional Director's site visit to San Juan—and includes the statement: "550 patients are maintained in 3 contract institutions for psychiatric treatment. I personally visited the largest of the contract hospitals, Hato Rey, which cares for approximately 300 of our patients and our VA patients represent 80 percent of that hospital's workload. The conditions which I found were totally unacceptable for any veteran patient * * *". "Background information would indicate that in 1971 and 1972 we attempted to move the patients out of the psychiatric contract facilities because of the conditions therein."

A report of contact of a telephone call from the Acting Director, VAMC San Juan made to the office of the Director of our Northeast Region, on July 25, 1980, included the statement: "that the ACOS for Ambulatory Care and Chief, Psychiatry Service inspected the contract hospital" * * * (i.e. Hato Rey) * * * . "on 7/24/80 and were displeased with their findings. The team's primary concern focused on inadequate staffing and space, i.e. insufficient physicians and nurses per patient and on the generally crowded conditions."

The report of a VA inspection team visit to the Hato Rey Psychiatric Contract Hospital on January 28, 1981, included the following observations and statements:

"* * * in summary, general professional staff is below standards * * * this obviously shows in poor overall medical care."

"There are two isolation rooms for restriction of very psychotic patients. No ventilation and poor illumination make this place unpleasant."

"At ward level the nursing personnel keep busy and interacting with patients. No organized activities were observed."

"The overall sanitation impressed poorly. There is evident overall crowding in the patient areas. Still odors in some ward and bath areas are offensive. There are multiple old water fixtures and a good number of these are in nonworking condition or working poorly. There was no hot water in two of the hospital wards on the day of the visit. . .". "Many of the bathrooms lack privacy, no doors or curtains to the showers or to the toilet." ". . . In the geriatric ward area there are two small booths with a bed in them which are absolutely small as a bed area. The roof in the casetas leaks continuously over a large portion of the ceiling."

A review of 15 medical records showed . . . "there was no clear indication that the problem list symptoms and signs were clearly elucidated. There was no clear indication as to the frequency of interventions, no clear definition of the therapy or procedures or by whom in specific."

A review of treatment showed . . . "in general, some patients had evidence of medical or neurological problems not properly followed up or cared for."

In the area of safety and fire protection:

"There is no written plan of action for orientation of new employees in accident prevention . . . fire procedures . . . reporting and records. . .".

"There is no . . . written preventive maintenance program for cleaning and testing of equipment . . .".

"There is no fire plan located as to be accessible to all hospital employees with specific evacuation routes".

"The emergency power plant does not transfer automatically within 10 seconds of the regular power source failure . . . it is manually operated."

"There is no fire alarm system arranged to transmit an alarm automatically to the fire department legally committed to serve the area in which the health care facility is located."

"There is no automatic sprinkler system installed with a water flow alarm connected to the fire alarm system."

"There are no stairway enclosures from the first to the third floor to provide an hour's fire resistant construction."

"There is no written policy to be enforced in case of a bomb threat with specific procedures applicable to services."

Many of these deficiencies had been observed on prior site visits—and recommendations had been made to Hato Rey management for their correction.

Finally, a memorandum dated February 3, 1982, from the Director of our Mental Health and Behavioral Sciences Service in Central Office and sent to our Assistant Chief Medical Director for Professional Services included the statement that:

"In addition, we have between 590 and 600 patients in contract hospitals on a typical day. These hospitals are owned by a prominent local psychiatrist. The per diem there is much less than in the medical center and the care is correspondingly less adequate. It is principally custodial care with some attention to management of pharmacologic treatment. Rehabilitation and other services are at a minimum so that the patients tend to stay for long periods. It is of interest to note that Psychiatry VAMC contracts in San Juan represent 48 percent of all VA contract hospital beds on any day. I have visited San Juan, and feel that contract hospital care cannot continue if we are to give even a pretense of adequate care to our patients there. In the plan for San Juan . . ." (VAMC) . . . "there are 400 new psychiatric beds. This will greatly facilitate care, and if we can have that many beds under our Service I am sure that will be adequate."

Mr. MOTTL. The report of March 10, 1981, to Congress. Four options are enumerated for the provision of inpatient care. These options range from the construction of no additional beds in Puerto Rico to the construction of nearly 500 beds.

From your vantage point of the four options presented, which would you opt for, Dr. Custis?

Dr. CUSTIS. I'm of the opinion, based on what evidence we have at hand that we do, indeed, need more psychiatric beds run by the VA in Puerto Rico. As to the sizing of it, we're not prepared to say as yet.

There's also demographic need in both the Virgin Islands and Puerto Rico for a greater capability for outpatient care.

Mr. MOTTL. With regard to the outpatient options. There are six, I think enumerated. Which ones would you opt for?

Dr. CUSTIS. Well, there's been no agency determination of that. It would have to be strictly a personal, tentative opinion.

Mr. **Mottl**. Yes.

Dr. **Custis**. That opinion would be a second outpatient clinic in Puerto Rico and an outpatient clinic in the Virgin Islands.

Mr. **Mottl**. Thank you very much, Dr. Custis. Mr. Hillis?

Mr. **Hillis**. Thank you, Mr. Chairman.

I certainly appreciate having your statement and frank assessment of the situation. Would you justify or could you justify, for instance, placing a construction project in Puerto Rico ahead of the 10 most needed projects which you've already transmitted to Congress?

How do you prioritize this situation?

Dr. **Custis**. If you'll forgive me, Mr. Hillis. I'm reluctant to bite on that.

This is fraught with so much concern right now. What those priorities really mean. What the criteria are for establishing such priorities that I really couldn't give you——

Mr. **Hillis**. I didn't mean that as a trick question. I hope you understand that, Doctor. I'm just sitting here listening to the description of some of the services that are now afforded to veteran population in Puerto Rico and from your own admission, they are not of the standard that they ought to be.

Dr. **Custis**. Without comparing one hospital with another, but just generalizing, I would say this is in the high priority need.

Mr. **Hillis**. Would it be fair to summarize that what you're telling us is that this does have a high degree of your attention. That you are going to suggest some alternatives as to how to cope with this situation, and that there is a problem but it will be dealt with to the best of your abilities in the near to immediate future?

Dr. **Custis**. Yes, sir.

Mr. **Hillis**. Does the VA have contract authority anywhere else similar to this authority in Puerto Rico?

Dr. **Custis**. Yes, sir. In Alaska and Hawaii, but not quite as liberal as in the case of Puerto Rico and the Virgin Islands.

Mr. **Hillis**. Mr. Chairman, I think that's all at this time.

Mr. **Mottl**. Thank you very much, Mr. Hillis.

The gentleman from Alabama, Mr. Smith?

Mr. **Albert Smith**. Thank you, Mr. Chairman.

Dr. Custis, I was asking questions of the previous testifier, a Member of our body, about if any studies had been done concerning return of patients to VA beds due to mental illness as compared to those that had been contracted out when the variants between 22 days average stay in the VA hospital as compared to 90 days average? Is any study underway along that line including information such as that to find out why there's such a great variance?

Dr. **Custis**. To the best of my knowledge, the answer is no, Mr. Congressman. I would like to comment on that, though. You would, indeed, have to study this in greater depth.

For example, let's take two hospitals anywhere in the world, psychiatric hospitals. In the case of one hospital, let's say that 10 percent of the patients there are very sick, and more or less permanently hospitalized. Their length of stay may be measured in years. Whereas, a second hospital might not have long-term capability and therefore would hold few cases for extended periods of time. Or perhaps, their census of chronic care patients would only be 1 percent.

No matter how rapid the turnover of the 90 percent in the case of the first hospital, it would be very difficult to arrive at an average length of stay in that hospital that would compare to that of the second hospital.

So, you can't say that because the average length of stay in one psychiatric hospital is 90 days and in another hospital, it's 22 days, that that is necessarily a reflection on the quality of care or the method of handling patients.

You'd have to know more about it.

Mr. **Albert Smith.** But I would think that this would disturb the VA to see variants of more than 4 to 1, the length of stay in a contract hospital or a hospital that contracts services, than it does in the VA hospital.

There ought to be some way to determine the quality of care, or also the question of repeat, and to know whether the VA is getting the return on its money and getting the services to provide for the veterans there as well as it is in the VA hospital.

From what you had said, I guess, in answer to the chairman, that some study is going to start or some investigation is underway?

Dr. **Custis.** A study has just been completed. And there's plenty of evidence in that study that the quality of care on the fee basis provisions is not good. In fact, in some cases, just very poor.

I did not mean to imply when I said that there's a group of us planning to go to Puerto Rico for a firsthand look at certain problems. I did not intend that to be an indication of another study per se.

The Congress and the VA both, if this provision for a 1-year extension is made during this year, is going to have to make some hard decisions. And I think those participating in that decisionmaking are well advised to get some firsthand knowledge of the situation.

Mr. **Albert Smith.** In this firsthand knowledge, would this include whether some hospitals are closer to the norm than others and possibly might not be permitted or that might rescind the contract or discontinue the contract?

Dr. **Custis.** That's a very real possibility.

Mr. **Albert Smith.** Do you have any idea how many hospitals have this service contracted to, in Puerto Rico?

Ms. **Quandt.** There are at least two which I'm familiar with.

Mr. **Albert Smith.** So, it's not a large number. It's just a few that this applies to.

Mr. Chairman, that completes the questions.

Dr. **Custis.** Mr. Chairman, the previous question that we said we'd respond to for the record, Ms. Quandt did locate the answer in her data here. If you'd like to have that?

Mr. **Mottl.** Yes; if you'd supply it, we'd appreciate it.

Ms. **Quandt.** We paid in fiscal year 1981, $12,821,000 on contract care in Puerto Rico. That was a cumulative census of 595 patients at an average per diem cost of $59.

Mr. **Mottl.** Thank you, Mr. Casteel, do you have a question?

Mr. CASTEEL. That is only inpatient. How about the contract here for fee basis? Outpatient care?

Ms. QUANDT. I'd have to get that.

Mr. CASTEEL. Our figures that we got early this morning from the Assistant Deputy Administrator for Budget and Finance indicates that the combined total in 1981 was in excess of $20 million. And the contract here for inpatients was in excess of $14 million.

Mr. MOTTL. Thank you very much. Mr. Smith, the gentleman from New Jersey?

Mr. CHRIS SMITH. Yes, Mr. Chairman, thank you.

Dr. Custis, it's good to see you again and thank you for your statement. I have a couple of questions.

First, on the State homes. Could you detail the need? As you know and as we all know, the World War II population is moving increasingly into the area where they may need the State homes versus our Federal ability to provide?

Dr. CUSTIS. The need versus our ability?

Mr. CHRIS SMITH. Like over the next 10-year period. Is that available?

Dr. CUSTIS. We know that by 1990, the need in terms of total veteran population for nursing homes will be something in the vicinity of 350,000.

Twenty percent of the VA's traditional market share for nursing home care will amount to something between 55,000 and 70,000 beds. We have been satisfying that share by providing inhouse, 40 percent; community nursing home, 40 percent; and State home, 20 percent.

Applying those percentages to that 55,000 to 70,000, you get a figure that identifies the need of something in the vicinity of 20,000 to 25,000 beds within the VA and half that number in State homes by 1990.

Mr. CHRIS SMITH. Thank you.

I think this subcommittee—that's the whole area, of course, that we've got to move into. Even more so.

Unfortunately, I have observed in my first year that very often we'll let things creep up on us and we'll not always plan the way we should and the crisis hits.

On flex time, I'm very interested in flex time. We recently had a vote on the House floor regarding it. I think it's good for morale. It's good for retention as well as recruitment.

It's particularly advantageous in the area of nurses, because we do have a nursing shortage in most hospitals, nursing home care and all kinds of health care. I was wondering if you had any statistical data on 4107-E-5 which you refer to as well as the experimental program of 95390, as to how that increased the amount of nurses that we have in VA health care delivery system?

Dr. CUSTIS. Are you truly referring to flex time or compressed work week?

Mr. CHRIS SMITH. Compressed work week is what I'm referring to on this one.

On that one I believe, that that also helps increase productivity.

Mr. MOTTL. Ms. Ferguson?

Ms. **Ferguson**. Thank you. I'm Vernice Ferguson. We're just beginning to tap the study data in using compensatory time in the VA system as a way of giving nurses more flexible hours.

In fact, after all of the mechanisms were put in place in October, we went out to the field this past week to get some fix on what is going in the system. And we noted that as of Monday, 142 VA medical centers—VA facilities responded to us.

You would be interested to know that it's not only the hospital where we're tasked to provide care 24 hours a day, 7 days a week, but outpatient clinics have also responded.

It is of interest to note that to date, out of 136 of our VA medical centers and 6 outpatient clinics, that responded, 57 VA medical centers and 2 outpatient clinics have instituted this compensatory time which gives them many options for many arrays of hours work per day.

We note that 31 VA medical centers are planning and 46 of them do not see a need at this time for this mechanism in the medical centers nor for outpatient clinics, which takes us back to Dr. Custis' statement about the geography of the issues related to recruitment and retention.

We note that of the tours of duty that are out there, 9-hour shifts account for 28 of the responders. The most popular tour of duty happens to be the 10-hour tour and not the 12-hour tour for 53 of our VA medical centers that have moved into this domain have asked for that.

The 11 tour accounts for 11 of those 59 facilities reporting and the 12-hour tour, 32. We are moving rapidly into some pilot projects through Public Law 96-330, section 118. We are taking a hard look, retrospectively, at the variants at Wadsworth, New Orleans, and Ann Arbor where they have the true compressed work week and all of these variations on a theme.

One of our key competitors in this very Washington area happens to be the VA Washington Hospital Center. That's on the grounds of the VA Medical Center. And I am reminded by chatting with our nurses there just on Tuesday, that one relief might well be three 12-hour tours and two 12-hour tours.

We're beginning to see that as we talk about advantages for the tour of our 57 VA hospitals that are giving us the response, 27 of them definitely cite improved morale as a real factor, better coverage to provide continuity of care because the tours of duty overlap and in 14 of them, in their sharing with us, it's a cost-effective solution to overtime.

We note that during peak periods, we're better staffed. But as we look at the disadvantages of the present mechanism, we find that timekeeping is tremendously complex.

We're not totally computerized. Moving back and forth with all of the variations on a theme with absence and all is creating some problems. And I would venture this may well be a reason why some have not embarked on the experience yet.

It is of interest to note that for the first time, we're hearing reports of fatigue due to the 12-hour tours, especially in our high-stress areas, like the ICU units. And when I coupled the fatigue level, I wanted to get an average figure for the age of the VA nurse who truly lays on the hands, the average nurse, who lays on the hands of the VA as a full-time nurse, and the average age of this group is 40 years of age. So, we're pushing up there as compared to the private sector where those who tend to find the 12-hour tour attractive in intensive care units, tend to be the very young nurses, newly graduated.

So, we're going to find variations on a theme but we feel the compensatory time mechanism and a movement toward different patterns of compression, giving the agencies the larger flexibility, rather than locking us into stone will really assist us.

Mr. Chris Smith. Thank you for your response. Just a further comment on that.

I understand that we currently have statutory authority to pay nurses a 25-percent premium for work on Sundays. Do you think if we apply that also to Saturdays that that would be helpful?

Ms. Ferguson. Very definitely. We're not competing favorably with the private sector when those who volunteer to work these hours for across the street, one could work the 24 hours and receive premium pay on Saturdays and Sundays.

But if you joined us in the VA, you would be penalized in the money you would take home because we do not have premium pay on Saturdays.

Our nurses are sharing with us. That would be one additional option. But we're all very clear that there's no single one that's going to get us out of these difficulties.

Mr. Chris Smith. How short of nurses are we, in the VA system?

Ms. Ferguson. The floating number changes on any day of the week. I would share with you that testimony earlier from one of the service organizations spoke to 800 nurses.

But we know that with the substantial number of beds closed, if we had an additional 300 to 400 nurses, at this time, with some of the flexible hours in place, and improved special salary spreads, we could reopen some of those beds.

I would share with you that there were cries of distress 1 year ago and this was true not only in the VA system but beyond. But we're beginning to see, as the economic picture is played as it is, that turnover rates historically drop among nurses in the Government at a time of difficult economics.

And whether or not nurses and managers are accommodating the new reality or it's a matter of, "I'm happy that I have a job and can support the family," we can't be too sure. But we're not hearing the strident voices of yesteryear. Because we're not, we're not arresting at just one issue.

We're moving in many nonmonetary satisfiers, too. And I think this bold movement, starting at the Administrator's Office and to Dr. Custis, we are moving toward repairing some of the problems that are not monetarily related.

Mr. Chris Smith. OK. Does the VA have a program to kind of sell this success? Because you talked about increased morale, you know, the fact that I know that in some regional areas, we do not have to be as competitive as in others.

But in order to attract even more nurses into—and retain them for longer periods of time. But for the one purpose of morale, I wonder if your success is being——

Ms. **Ferguson**. Surely. We're selling better for we have the opportunity of a monthly hotline and we use that hotline with all nursing services to interact with each other, to raise some of these successes as well as the problems.

We feel very strongly that the VA has an awful lot of strengths and I bring special pathology with me that before you tell me your problem, tell me all the things that are good about the VA. And we're hearing those kinds of success stories on our hotline.

In addition, we have great emphasis in a recruitment program using the opportunities that exist with personnel and with information service, more recently. Information service is moving very boldly at the instruction of Mr. Hagel, to help tell the VA nursing story.

So, we feel we will have much more positive visibility in the press in the months to come.

Mr. **Chris Smith**. Keep up the good work.

Mr. **Mottl**. Thank you very much, Mr. Smith.

Before we leave Puerto Rico and get back to the nurses, Dr. Custis, as this subcommittee chairman, I want to make sure that every service veteran in Puerto Rico gets the same quality of medical care that any veteran in the Continental United States would receive.

To me, the service-connection of the psychiatric problems should be looked into. That's the reason I've asked for the Inspector General to look into this, also because we have an obligation not only to the veteran but to the taxpayers of the United States.

To me, this entire situation smells there in Puerto Rico as far as the taxpayer being ripped off. And, I think this deserves your immediate attention. If, after you've been to Puerto Rico, you either want to recommend it to this committee that we build additional wings, have additional beds. This might be much more economical than paying $20 million for a fee basis that we have to pay. So be it.

But I think this should be looked into forthwith by you personally and your staff to make sure we have a quality of medical care necessary for the veterans of Puerto Rico and also that the taxpayer is not being ripped off.

There has been a ripoff in this area, let's bring those people to justice. Do you agree with me?

Dr. **Custis**. Yes, sir, Mr. Chairman, I do.

Mr. **Mottl**. Getting back to the nurses. Dr. Custis, we are hearing more and more from hospital directors, chiefs of staff, chiefs of nursing services, about the increased difficulties in competing with the private sector in the recruitment or retention of registered nurses.

Most of the VA personnel say this is due to salary competition and other fringe benefits first and work schedules second. Just yesterday, a member of staff was contacted by a hospital director who related the tremendous difficulties encountered in trying to keep the intensive care unit open on the weekend.

Yet in your prepared statement, you indicate that you do not favor the enactment of a structured, defined program such as the Baylor plan. It seems to me we are up against a situation that requires action in the immediate future if we are to provide the quality care for eligible veterans.

Do you have an alternative at this time that would permit the VA to resolve this difficult problem?

Dr. CUSTIS. Now, you're referring specifically to the problems regarding weekend coverage, Mr. Chairman?

Mr. MOTTL. Basically, to the entire problem of nurses. But especially to the weekend.

Dr. CUSTIS. We can with present authority increase the pay per hour so that an individual who is interested in working a weekend shift of 24 hours can—we can, with our present authority, using premium pay for Sunday, pay that individual for what is the equivalent of 32 hours.

We cannot match the Baylor plan of 40 hours for a 24-hour weekend. I think most of us in the agencies, somehow feel that there is just something wrong with paying individuals for hours they don't work. We would far rather increase the rate of pay so that they're paid for the hours they do work at a competitive scale with the community.

As I say, we have the authority now to increase the pay for the hours they do work, but not to the extent of total competition with the Baylor plan.

As regards the rest of the week, as we've said, we really feel that the compressed workweek, where it's been applied, has been very successful. And what we have left are very spotty areas of crisis.

We are continuing to consider what our options are. How we can best make use of the authority we do have. I would defer to Mr. Hendricks. But I understand, for example, that it may be that we would desire better clarification in our legislative authority in the handling of the compressed workweek; is that right?

Mr. HENDRICKS. Yes.

Mr. MOTTL. Dr. Custis, would you please tell the subcommittee how many VA hospital beds are currently closed because of the VA's inability to recruit and retain nursing personnel to staff them?

It's reported that there's about at least 800; is that true?

Dr. CUSTIS. That 800 count——

Ms. FERGUSON. May I? The 800 count that has often been cited was our count when the nursing service cascaded out to every medical center in July and August to determine the number of beds closed. It is of interest to note that that is a period in every hospital's life that it has a smaller population. Generally, if nurses are going to resign, they will do it somewhere between April and June in order to enjoy the summer months, et cetera. And we've not gotten the bonus of the new graduates who, generally, will take the summer off and join us in September.

So, we've had improvement in that large figure.

Mr. MOTTL. You're saying there isn't a shortage now of nurses?

Ms. FERGUSON. No; I'm not saying that.

Mr. MOTTL. What is the shortage? Your best estimate?

Dr. CUSTIS. Our best estimate is that we could hire tomorrow as many as 800 nurses. If we were successful tomorrow in hiring 300 nurses, and if they were properly placed to relieve the geographic problems, we could change the entire situation. It would ease it considerably.

No, we do not have a hard, authorized ceiling as for example, military medicine does. The Director has the flexibility with FTE and personal service dollars to hire more of one category of health professional and less of another.

He's got the flexibility to meet his needs. He's got the FTE out there now and the personal service dollars to hire nurses. But he has not been assigned a ceiling. He has not been assigned a specific number and we can't respond, categorically, saying we have *x* number of vacancies for that reason.

Mr. MOTTL. Yes; I would yield at this time to the distinguished counsel of the full committee, Mr. Fleming.

Mr. FLEMING. Dr. Custis, the question here is critical, I think, both from the chairman's standpoint and it is critical to the latter question asked by Mr. Smith of New Jersey.

It's not a question of not having the flexibility because I think everyone agrees the directors do have the flexibility. But beds are closed because of the nursing shortage. Whether it's 800 today as it was in July, we don't know. But we do know that beds are closed, and they are closed in areas where they shouldn't be closed. They are closed in the larger urban hospitals where it is so hard to recruit and retain nurses because of the competition.

Mr. Montgomery's bill is discretionary. It doesn't mandate that the agency pay anybody, anything, any time. It just simply gives management another tool so that if there are nurses available who could work only on weekends, they would be able to do so. By the way, we're not talking about nurses "pushing 40." We're talking about younger nurses with small children, who would like two sources of income but they can't work because they must care for their children during the week. Under the Baylor plan, they are allowed to work the weekends while their husbands take care of the children. And they then are off to care for the children while the husband works.

So, we are talking about younger nurses. We're not talking about those who have reached the age of 40 or above.

But, what puzzles me about this is why the Chief Medical Director would not want this additional management tool. Would it not be advantageous to have discretionary authority to hire nurses to work the 12-hour shift on the weekend, if they would be willing to do that?

Maybe they would be a little more tired, by having worked a 12-hour shift, but nonetheless, they would be there and that bed will be available for a sick veteran where otherwise, it would be closed.

No one likes to pay nurses working 24 hours for 40 hours pay. But I would suggest to you that some Members have never enjoyed the idea of having to pay physicians the salaries we must pay physicians in VA hospitals in order to get them in areas to where we know the market calls for special and incentive pay in addition to their basic pay.

Dr. CUSTIS. I always thought Congressmen derived a lot of satisfaction in paying physicians.

Mr. FLEMING. Congress recognized it had to pass legislation, providing primary and special incentive pay to physicians only because that's the only way the agency could get them. That's the main point, Mr. Chairman.

Mr. **Mottl**. Did you have a comment to that, doctor?

Dr. **Custis**. No, I think not.

Mr. **Mottl**. Don't you trust your Administration? If you have another tool do you think it will be abused, is that what you're trying to tell us or——

Mr. **Hendricks**. Mr. Chairman, I think the answer is, as we've discussed in the agency, that we would like to study the problem further. As you've heard, the testimony has been that the problem has, apparently, abated to some extent. That the remedy provided by the Baylor plan is rigid and as I think, Ms. Ferguson described it, locked in.

We did say in our study we would like to study this further and perhaps come up with a proposal for some sort of more flexible solution to the problem than just a 24-hour Baylor plan.

Mr. **Fleming**. But that's only one option. No one suggested that there can't be others that may be better or more effective. All we're suggesting here is that this proposal is just an option that you might want to consider.

Mr. **Mottl**. Mr. Casteel, do you have a question?

Mr. **Casteel**. I'd just like to add, Mr. Chairman, that a lot of the complaints I hear from nurses themselves and from the directors of nursing services, is from the young nurses who are currently employed in the VA, that you cannot guarantee them even one weekend in three off much less one in two or every weekend.

And this is another option that you would have to try to resolve that problem of retaining those that you currently have that are young, unmarried, usually, they want the weekend off to go to the beach.

Mr. **Mottl**. Mr. Wilson, did you have any questions here?

Mr. **Wilson**. Dr. Custis, Ms. Ferguson, could you tell us what adverse effect there is, if any, on a nurse who works 12 hours 2 or 3 days in a row?

Ms. **Ferguson**. Some nurses express concerns about unusual fatigue as they carry on the 12 hours in that consistent pattern. One of the adverse effects in terms of morale, and this was found with the Baylor plan people, was the matter of putting the option out and then trying to make the very, very hard choice of those who will be given the privilege to work the weekend and carryoff the 40 hours versus those who would have to work Mondays through Fridays.

So, one of the adverse impacts would be the administration of the plan in determining those who would qualify or how one would permit and allow nurses to work.

One other problem that we foresee and has been voiced by many of our chief nurses and head nurses and coordinators who plan the schedules is you have gained 24 hours of consistent work but you've lost 16 other hours that have to be made up somewhere because the bodies must be in place to care for patients on evenings, nights, and days, Monday through Friday.

The question then becomes, if you're already short of staff, and you've truncated the work week, you have some hours to make up and you need some bodies. And one of the problems in some of the areas where the supply of nurses is small, that there's no one else to hire even though you have some bucks and some dollars to do it. So, there's a disconnect there.

Mr. **Wilson**. Ms. Ferguson, in response to Mr. Smith's question that would it be helpful if you had premium pay authority for Saturdays. I think you responded yes. Do you have any cost factor on that?

Ms. **Ferguson**. I don't. Not at my fingertips.

Mr. **Wilson**. Would you know offhand what the Sunday premium cost is?

Ms. **Ferguson**. Some of my colleagues here? Do you have any hard data on it? I don't have any hard data on that. We can supply it, surely.

[Subsequently, the Veterans' Administration provided the following information:]

The VA estimates the total cost per year to all VA medical centers for Sunday premium pay is $10,913,760.

Mr. **Wilson**. Just one final question. Whatever the figure is, the number of beds that have been closed because of the lack of nurses, if you solve the nursing recruitment problem and the nursing retention problem, would those beds be reopened?

Ms. **Ferguson**. From a nursing standpoint, yes, they would. If we solved the recruitment and retention problem.

Mr. **Mottl**. Thank you very much.

If an individual in an extended care facility is an eligible veteran and VA resources are not being used to optimum capacity, as you say in your statement, why would you not admit the veteran and provide him care as you would other veterans?

Under present law, I cannot see how you could deny such a veteran care, within the limits of the VA facilities?

Dr. **Custis**. I'm sorry, Mr. Chairman. I didn't understand the question.

Mr. **Mottl**. All right. If an individual in a State extended care facility is an eligible veteran, the VA resources are not being used to optimum capacity, as you say in your statement. Why would you not admit the veteran and provide him care as you would any other veteran? Under the present law, I cannot see how you could deny such a veteran care, within the limits of the VA facility.

Mr. **Casteel**. Doctor, do you propose to enter into sharing agreements with State extended care facilities, State homes? And saying that on a reimbursable basis, you would take those that required more sophisticated care in the VA in a capacity that is not currently being used to the optimum basis?

And that you would get reimbursed from the State for the care of that veteran? And I think that's the question the chairman is asking.

Dr. **Custis**. I would think that that would be something we could, indeed, do. I'm still not clear as to the intent of the question.

Mr. **Casteel**. The intent of the question is to determine whether or not you are going to charge, on a reimbursable basis, a State home for the care of an eligible veteran in a VA operated hospital? That's the question, and that's what we gain from your statement. That you would enter into sharing agreements with them and provide the sophisticated care within VA hospitals.

Dr. CUSTIS. At the present time, as far as I know, a veteran who is in a State home who develops a need for hospital care, does have a VA hospital bed available to him.

Mr. CASTEEL. That was our understanding, but we were getting something else from your prepared statement.

Dr. CUSTIS. I think the prepared statement references the potential of furnishing, on a quick reference, even out-patient ambulatory basis, backup to a State hospital that doesn't have the sophisticated capability that a neighboring VA hospital has.

Mr. MOTTL. Dr. Custis, have you received comments from any of the various States, any proposed initiatives to have them contract with the VA for sophisticated medical services and if so, what were they?

Dr. CUSTIS. Are you asking what the current level requests are for grants, is that the question?

Mr. MOTTL. No.

Dr. CUSTIS. If I can go back to the second question or the previous question, for just a second Mr. Chairman.

Under greater arrangement for sharing, I think the intent there is that we would provide total backup to a State hospital on a sharing basis, whether or not the patient receiving it, was or was not a veteran.

Mr. CASTEEL. Doctor, on page 3 of your prepared statement, talking about grant authority and the expansion of this authority. And you say there is an incentive to engage in such sharing because reimbursement are credited to the medical appropriation.

Our challenge is to apply that authority to the development of agreements. You indicate in your statement, that you would provide on a reimbursable basis, the sophisticated care that is not currently being used to an optimum within the VA facility.

Dr. CUSTIS. This would involve a nonveteran patient that the State would be paying us for.

Mr. CASTEEL. A nonveteran. That was not clear in your statement.

Dr. CUSTIS. We have such sharing arrangements, for example, with some of our university hospitals that are affiliated. We may share special medical programs and the equipment that's associated with those programs.

Mr. CASTEEL. Then it would not be your intent to try to seek reimbursement for a veteran patient?

Dr. CUSTIS. No, sir. We would not be authorized to.

Mr. CASTEEL. I'm glad you cleared that up.

Dr. CUSTIS. I think that's why I was so confused as you opened the question. The veteran now in a State home certainly can turn to the VA for hospitalization when need be.

Mr. CASTEEL. That wasn't very clear.

Mr. MOTTL. Thank you, Dr. Custis.

Mr. Smith from New Jersey, do you have a question?

Mr. CHRIS SMITH. I just have one further question. In the prepared testimony of the "Paralyzed Veterans," I note that as of October 1981, there's a shortage of 1,200 RN's and 900 LPN's. Has that been changed since then?

Ms. Ferguson?

Ms. FERGUSON. It's been reduced.

Mr. CHRIS SMITH. OK, good.

Mr. MOTTL. Thank you, Mr. Smith.

Mr. Smith of Alabama, any further questions?

Mr. ALBERT SMITH. No question, Mr. Chairman.

Mr. MOTTL. Dr. Custis, we want to thank you once again for your outstanding job you have done here this morning and we certainly appreciate all your colleagues joining you.

Dr. CUSTIS. Thank you.

Mr. MOTTL. Thank you.

Next, we'll have a panel of three veterans groups. We'll have Mr. Gordon H. Mansfield, associate legislative director of the Paralyzed Veterans of America. Joining him at the table will be Mr. James N. Magill, special assistant, National Legislative Service, Veterans of Foreign Wars, and Mr. Paul Egan, deputy director, National Legislative Commission of the American Legion.

If you would all come forward, please?

We want to welcome you three gentlemen here this morning and we'll first hear from Mr. Gordon Mansfield, associate legislative director, PVA.

Mr. Mansfield, your entire statement will be submitted into the record without objection, entered into the record.[1] You may summarize or read from your prepared text. Whatever you feel more comfortable with.

STATEMENT OF GORDON H. MANSFIELD, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. MANSFIELD. Thank you, Mr. Chairman.

In the interests of time and considering the testimony we've already received, I'd like to proceed in that manner.

First, concerning the extension of contract care or fee basis care for Puerto Rico and the Virgin Islands, PVA supports the continuation of this for at least 1 additional year.

I think the excellent testimony received here earlier this morning points out that there is a unique serious situation existing in Puerto Rico and the Virgin Islands and that the committee should continue the present system at least for a year while the committee and the VA and other interested parties decide on which of the options they are going to follow.

PVA is especially supportive of proposed legislation designed to assist in the recruitment and retention of qualified nursing personnel. We've heard testimony here this morning indicating that there is a shortage, whatever the numbers are. And we realize that it fluctuates from day to day.

But the one fact is, there is a shortage. There are beds closed that could be opened if there were additional nurses in the VA system. PVA would support policies that would be designed to recruit and retain additional nursing personnel.

I believe that the experience of the private sector in using programs such as the Baylor plan or the alternative weekend work week, compressed work week schedules and flex time, have shown that the nursing personnel out there desire these types of opportunities to be able to plan their work schedule.

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[1] See p. 63.

And one point I'd like to make here is that we talk about a nursing shortage. I don't believe that there's a nursing shortage per se in the United States. There's a shortage of working nurses. And any plan that would be able to get more of these nurses back into the hospital work even if only for 2 days a week would be beneficial and beneficial to the VA system.

With regard to the legislation proposing extension of grants, PVA supports this legislation. With regard to the grants for State nursing homes, I believe the extension of authority is especially important at this time, when the number of aging veterans is increasing.

Also, we've just seen the failure of the administration to provide funding for any additional geriatric research education and clinical centers in the fiscal year 1983 budget.

And, therefore, feel a need exists to continue other VA efforts to care for our Nation's older veterans.

PVA also supports the exchange of medical information program which we feel is designed to attract and retain highly trained and qualified members of the medical profession. And, finally, Mr. Chairman, PVA supports extension of authority to provide grants to the medical schools which assist such schools to expand and improve their training capabilities.

Thank you, Mr. Chairman.

Mr. MOTTL. Thank you very much, Mr. Mansfield, for your excellent statement.

[The prepared statement of Mr. Mansfield appears on p. 63.]

Mr. MOTTL. We'll next hear the statement of the representative from the Veterans of Foreign Wars, Mr. Magill.

STATEMENT OF JAMES N. MAGILL, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. MAGILL. Mr. Chairman, thank you for the opportunity to present the views of the VFW with regard to the various program extensions.

I will briefly, summarize my statement.

Mr. MOTTL. Your entire statement will be submitted to the record, without objection.

Mr. MAGILL. Contract care is authorized for certain veterans in Puerto Rico because the VA does not have adequate facilities there to meet the demand.

The VA completed a study on the health care needs of our veterans in this area and has suggested expanding the medical facility in Puerto Rico. The VFW agrees with and supports this recommendation. In doing so, we support the extension of contract authority until a facility expansion can be authorized and made operational.

The next proposal, H.R. 5737, introduced by you, extends for 3 years the exchange of medical information program and the authority for the VA to make grants to affiliated medical schools. The VFW supports this bill extending these two programs.

Finally, Mr. Chairman, the next measure before us provides flexible hours for compressed work schedules for VA registered nurses. We support this concept to make the VA more competitive with the private sector in the improvement and retention of registered nurses. We take this position with the understanding that the high quality care received by our Nation's veterans will not be compromised.

This concludes my statement. I'll be happy to respond to any questions you may have.

[The prepared statement of Mr. Magill appears on p. 71.]

Mr. **MOTTL**. Thank you very much, Mr. Magill, for your fine statement.

Next we'll hear from Mr. Paul Egan who represents the American Legion.

STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. **EGAN**. Mr. Chairman, I have with me here this morning, John Sommer deputy director of our Veterans Affairs and Rehabilitation Division. He'll summarize our statement and at the conclusion of that statement, we'll both be available for questioning.

Mr. **MOTTL**. Without objection, your entire statement will be submitted for the record and you may summarize.

Mr. **SOMMER**. Thank you, Mr. Chairman.

The American Legion views favorably each of the proposals under your consideration today. We especially wish to express our support for section 1 of H.R. 5737, authorizing the appropriation of funds for the purpose of making grants to the States for the construction, remodeling, and renovating of State veterans homes. And for the proposal to authorize the provision of flexible hours or a compressed work schedule for nurses in the VA medical centers.

The American Legion is very much aware of the critical shortage of nurses in the VA medical care system, where this shortage has led to the closure of beds, wards, and intensive care units interfering with the delivery of quality medical care.

Recruitment and retention of registered nurses in the VA has become increasingly difficult because the compensation and fringe benefits are inadequate in comparison with those offered in the private sector.

Mr. Chairman, I'm now going to depart from my prepared statement altogether in order to present additional material which we have gathered in support of this proposed legislation. I have with me 57 reports on visits to VA medical centers prepared by the Legion's National Field Service staff between August 1979 and January 1982.

These account for one-third of the visits made during that period of time. Some of the reports are no longer accurate and I realize that the figure that I have is not an accurate figure today, but it shows the problems that have occurred.

These reports reflect a cumulative shortage of almost 2,000 registered nurses.

I would now like to provide the subcommittee with information lifted from these reports which reflects the urgency of this situation.

Wood, Wis. VAMC, May 1981. Staffing shortages especially within the nursing service, have already placed patient care in jeopardy. Ceiling is available for additional nurses, but recruitment is impossible.

Reportedly, there are 800 registered nurse vacancies within the Milwaukee area. Everyone offers or pays more than the VA, thereby amplifying the problem for VAMC Wood.

Currently, due to insufficient nursing personnel, a six-bed cardiac care unit, a six-bed stepdown unit and a 40-bed ward are closed.

Wadsworth VAMC, Los Angeles, June 1981. At the time of the survey, nursing service reported 47 registered nurse vacancies. As a direct consequence of the inadequate nursing support, the surgical intensive care unit is only operating 6 beds even though 15 beds are authorized.

The medical intensive care unit is authorized 10 beds but can only operate 6 of these. Subsequently, a less than desirable situation exists.

Nashville VAMC, September 1981. Nursing service reported that recruitment is in progress for 12 registered nurses. Recently, this medical center was forced to temporarily close four medical intensive care unit beds because of the vacancies that existed for critical nurses.

The chief nurse stated that recruitment and retention of nurses is becoming increasingly difficult due to the salaries and the benefits that are offered in private sector.

Houston VAMC, October 1981. A high turnover in skilled nurses for intensive care and coronary care is being noted. This primarily is due to salary differential in community hospitals. Those leaving the VA can earn $4,000 to $5,000 more at other health care facilities in addition to having select working hours.

Danville, Ill., October 1981. Of particular concern to the director is the difficulty in the recruitment and retention of registered nurses. Although the medical center is offering a competitive salary, it cannot match the benefits that are being offered in the private sector.

Chillicothe, Ohio, VAMC, October 1981. Nursing service reports that recruitment is in progress for 16 registered nurses and 28 LPN's. It's expected that the nurse vacancies will be difficult, if not impossible to fill.

Recently, the Ross County Medical Center which is located near the VAMC, offered its nurses a new package of benefits; tuition reimbursement, compressed time and flex time, as well as a salary increase.

A study of the problem at Chillicothe showed that 76 percent who left did so to accept jobs with better pay and benefits.

Dallas VAMC, October 1981. Nursing service: Without a doubt, this is perhaps the most acute service lacking in personnel. There's a shortage of nurses in all intensive care units. Vacancies exist for 12 full-time nurses.

Because of the Baylor plan throughout the Dallas area, the VA cannot compete for nursing personnel. This plan permits other hospitals in the area to pay 40 hour wages to persons working two 12 hour shifts on weekends. As a result, it is impossible to recruit.

Wilmington, Del., November 1981. There's a critical shortage of nurses at this facility. There were 14 vacancies at the time of the survey. This nurse shortage has caused a number of other problems to surface. The 34 beds located on the eighth floor had to be closed. The ward coverage has been minimal.

Seriously ill patients have to be held longer in MICU to insure proper treatment.

Gainesville, Fla., January 1982. Nursing service is currently experiencing serious recruitment and retention problems. Just 1 year ago, this service maintained a stable work force of nurses. As of late, however, community hospitals have substantially increased nursing salaries.

This coupled with their attractive benefit packages is causing VA nurses to transfer, and new nurses to bypass the VA altogether.

Our staff was in Philadelphia last week and found that a shortage of nurses has caused the closing of 14 surgical beds in the Philadelphia VA medical center.

So, as you can see, the list goes on and on. And the problem will only continue to worsen unless fringe benefits and inducements are included to attract nurses to VA service.

The American Legion strongly urges favorable action on this proposal. An exacting need for flexibility in providing fringe benefits within the nursing service has been demonstrated and the Legion feels the time to act is now.

[The prepared statement of The American Legion appears on p. 74.]

Mr. Mottl. Thank you very much, Mr. Sommer and Mr. Egan. We certainly appreciate your bringing forth those important facts to verify there is a critical nursing shortage.

Would all of you gentlemen agree then that the Baylor plan is needed? That any additional tools that would be available to help attract or retain nurses would be helpful?

Mr. Sommer. Mr. Chairman, I would say that some plan is needed. We realize that the Veterans' Administration has initiated some action in order to attempt to recruit additional nurses.

One of these is the use of 30 nurse recruiters. However, we've also found that some of these nurse recruiters are striking out because they don't have the benefit packages to offer graduating nurses that the hospitals in the private sector do have.

We feel that this would be a big help, a useful tool to the Veterans' Administration and as Mr. Fleming mentioned earlier, it would not be binding upon the VA to use this but it would give them the authority to use some plan in order to attract more nurses.

Mr. Mottl. Thank you.

Mr. Mansfield?

Mr. Mansfield. Yes, Mr. Chairman. I would agree but I'd like to point out that the Baylor plan alone is not the answer. I think the VA has started to work toward the answer with Ms. Ferguson's activities in investigating the areas and developing plans.

But I think the key thing is the VA needs a complete package of available tools to work with including hours and benefits.

Mr. Mottl. The additional tool of the Baylor plan would be helpful then?

Mr. **Mansfield**. Yes, sir, I believe it would be one helpful tool. It's not the answer as was addressed here. If you put those nurses to work for two 12-hour shifts on the weekend, you have to cover an additional 16 hours someplace else. So, it has to be considered within the framework of total care for the veteran that's in the bed.

Mr. **Mottl**. Thank you. Mr. Magill?

Mr. **Magill**. Yes, sir. We believe that either the Baylor plan or possibly some variation is needed to get the VA up to the nursing level that they need.

Mr. **Mottl**. As an additional tool?

Mr. **Magill**. Yes, sir.

Mr. **Mottl**. Thank you.

Mr. Smith, do you have any questions of this distinguished panel?

Mr. **Chris Smith**. Mr. Mansfield, you strongly endorse the grants to medical schools and the authority for exchange of medical information. Could you elaborate on your very obvious disagreement with Dr. Custis' statement, in which he said that now 15 years after its start, the pilot grant program has essentially accomplished its purpose.

That is to say the exchange of information and elsewhere, on page 4, where he said, that we view this program as having largely served its purpose. That is to say, the grants to VA affiliated medical schools.

This is what I'm saying. Why do you really believe that this should be continued?

Mr. **Mansfield**. I believe the last sentence on page 7 is probably one of the major reasons the PVA believes in the program.

It's an important tool for retaining qualified medical professionals and one of the reasons we would request it be extended is that it's a possibility of offsetting what has been in effect, a reduction over the last 2 fiscal years of funding areas such as research which have an effect on retention of medical doctors and other personnel.

That's the first question. I'm sorry. I didn't follow you. You mentioned page 4.

Mr. **Chris Smith**. It was really the same thing, in which he said that the need is no longer there for those two programs.

Mr. **Mansfield**. I think you're—I believe the need is there. To continue to work to retain and recruit qualified medical professionals to the VA system. I believe these programs will assist us.

Mr. **Chris Smith**. Second question and this is really as Mr. Egan and also, I guess, you, Mr. Mansfield, you mentioned that there's about a 2,000 nursing shortage. You mentioned, I think 1,600? As of October? 1,200 and 900—and Ms. Ferguson mentioned something upwards of about 800.

I'm having trouble dealing with that discrepancy.

Mr. **Mansfield**. Sir, I believe part of the problem is—I'm not sure if it was Dr. Ferguson or Ms. Ferguson. Excuse me, Dr. Custis or Ms. Ferguson indicated. The VA medical center directors have a flexibility in determining how many RN's, how many LPN's, how many nurses aides are going to go into their patient mix.

The other thing is that you can take these figures on any day and it's going to change from day to day. And there are seasonal fluctuations as Ms. Ferguson indicated. But I think the main point to remember here is that there are shortages. And they do need some tools to correct that, no matter what the shortage is.

Mr. **Sommer**. John Sommer with the American Legion. As I mentioned in my statement, this is not a total as of today. This is what is reflected in the 57 reports ranging from August of 1979 until January of 1982 which cover approximately one-third of the hospitals that our field service staff has visited in that time.

There have been changes, certainly, since then, but I just wanted to point out the urgency of the situation; the problem that existed at the time that our field service representatives visited these medical centers.

Mr. **Chris Smith**. Is there any kind of agreement on criteria in terms of mix? For instance, in a given hospital, when your team went in, did they pretty much come up with the same recommendations that the VA personnel were coming up with? Was there any comparison?

Mr. **Mansfield**. I think a lot of that is a medical judgment. Because even work in a hospital between medical wards and surgical wards and intensive care units and spinal cord injury units, you have to have a different mix.

Mr. **Chris Smith**. Perhaps you could comment on one final question. Dr. Custis indicated that 350 or so strategically placed nurses would really help us in terms of covering the needs and would get us up to, almost optimum levels, I assume.

Do you think that's true? Of course, we'd like 350 more nurses. But he was talking about strategically located?

Mr. **Sommer**. Based on the information that we have available to us, I would say that the 350 nurses would probably reopen a number of closed beds, probably in the neighborhood of 800 or somewhere thereabout.

But it would still not bring the VA medical care system up to optimum care capability.

Mr. **Mansfield**. I would agree that I'd like to see 350 more nurses at work today. The figure may change tomorrow.

One other thing I think you need to take into consideration, Mr. Congressman. The fact that we're talking about a VA system that's nationwide. And if you talk about 172 facilities that's two nurses per facility, roughly.

Mr. **Chris Smith**. Thank you.

Mr. **Mottl**. Thank you very much, Mr. Smith.

Mr. Casteel, do you have some questions?

Mr. **Casteel**. Very briefly, I have a question for Mr. Sommer. Just to get this in the record.

When your field service representatives make those reports before they leave the VA hospital concerned, do they discuss these with the director?

Mr. **Sommer**. Yes, sir, they do.

Mr. **Casteel**. And generally the director is in agreement with the statements made in the reports?

Mr. **Sommer**. Many of the figures quoted in these reports came from the director of the facility.

Mr. **Casteel**. Now, also, just to get this in the record. Do you furnish copies of that report to the Veterans' Administration Central Office?

Mr. **Sommer**. We furnish copies of these reports not only to VA Central Office but within the past year, we've been submitting them to the Members of Congress, serving the jurisdiction of the VA medical centers, as well as the Senators.

Mr. **Casteel**. I would like to say, Mr. Chairman, we get copies of these reports and they're very helpful.

Mr. **Mottl**. Any other questions?

[No response.]

Mr. **Mottl**. On behalf of the subcommittee, we want to thank you for your outstanding contribution here this morning.

I think you have verified the need for additional tools to hire and retain nurses to provide that quality of health care that all of our veterans really need. So, I think you've done a great job in bringing out the important facts that there is a critical shortage still in the VA system.

Thank you very much for being with us this morning.

[Whereupon, at 11:10 a.m., the hearing in the above-entitled matter was adjourned.]

APPENDIX

97TH CONGRESS
2D SESSION

H. R. 5737

To extend expiring authorities of the Veterans' Administration to make grants related to State nursing home facilities, exchange of medical information, and support of medical schools.

IN THE HOUSE OF REPRESENTATIVES

MARCH 4, 1982

Mr. MOTTL introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To extend expiring authorities of the Veterans' Administration to make grants related to State nursing home facilities, exchange of medical information, and support of medical schools.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the first sentence of section 5033(a) of title 38, United States Code, is amended to read as follows: "There is hereby authorized to be appropriated such sums as may be necessary for fiscal year 1982 and for the three succeeding fiscal years.".

SEC. 2. The first sentence of section 5055(c)(1) of title 38, United States Code, is amended to read as follows: "There is hereby authorized to be appropriated $4,000,000 for fiscal year 1982 and such sums as may be necessary for the three succeeding fiscal years for the purpose of developing and carrying out medical information programs under this section on a pilot program basis and for the grants authority in subsection (b) of this section.".

SEC. 3. Subsection (a) of section 5082 of title 38, United States Code, is amended to read as follows:

"(a) There is authorized to be appropriated for carrying out programs authorized under this chapter $30,000,000 for fiscal year 1982 and such sums as may be necessary for the three succeeding fiscal years.".

(Original signature of Member)

97th CONGRESS
2d SESSION

H.R.

Insert title here ☞

To amend title 38, United States Code, to authorize the Administrator of Veterans' Affairs to provide that Veterans' Administration nurses who work two 12-hour regularly-scheduled tours of duty over a weekend shall be considered to have worked a full basic workweek.

IN THE HOUSE OF REPRESENTATIVES

________, 19__

Insert sponsor's names here ☞

Mr. Montgomery introduced the following bill; which was referred to the Committee on __________

A BILL

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 4107 of title 38, United States Code, is amended by adding at the end the following subsection:

''(h)(1) In order to achieve and maintain adequate nurse staffing levels at any Veterans' Administration health-care facility, the Administrator may provide that a nurse employed at such facility who was appointed under section 4104 of this title and who works two regularly scheduled 12-hour tours of duty within the period beginning at midnight Friday and ending at midnight Sunday of any weekend shall be considered for all purposes (except computation of full-time equivalent employees for determining personnel ceilings) to have have worked a full basic workweek.

''(2)(A) A nurse who works a basic workweek as described in paragraph (1) of this subsection is entitled to basic pay as prescribed in subparagraphs (B) and (C) of this paragraph.

''(B)(i) The hourly rate of basic pay for such a nurse for service performed between midnight Friday and midnight Sunday of any weekend as part of a regularly scheduled 12-hour tour of duty shall be derived by dividing the nurse's annual rate of basic pay by one thousand two hundred and forty-eight.

''(ii) The hourly rate of basic pay for such nurse for other service shall be derived by dividing the nurse's annual rate of basic pay by two thousand and eighty. [Why is this necessary?]

''(C) Such a nurse is not entitled to overtime pay under subsection (e)(5) of this section for any period of service performed in excess of the regularly scheduled 24-hour basic workweek described in paragraph (1) of this subsection unless the total officially ordered or approved service performed during an administrative workweek is in excess of forty hours or is in excess of eight hours on a day not included in the nurse's regularly scheduled 24-hour basic workweek or is in excess of 12 hours on a day included in the nurse's regularly scheduled 24-hour basic workweek.

''(D) Except as provided under subparagraph (C) of this paragraph, such nurse is not entitled to additional pay under subsection (e) of this section for any period included in such nurse's regularly scheduled 24-hour basic workweek.

''(E) A nurse who is absent on approved sick leave or annual leave during a regularly scheduled 24-hour basic workweek described in paragraph (1) of this subsection shall be charged for such leave at a rate of five hours of leave for three hours of absence.

''(3) The Administrator shall prescribe regulations for the administration of this section.''.

SEC. 2. The amendment made by the first section of this Act shall take effect with the first pay period beginning on or after October 1, 1982.

(Original signature of Member)

97 CONGRESS
2d SESSION

H.R.

Insert title here ☞

To amend title 38, United States Code, to extend for one year the authority for the provision of Veterans' Administration health care by contract in the Commonwealth of Puerto Rico and in the Virgin Islands.

IN THE HOUSE OF REPRESENTATIVES

________, 19__

Insert sponsor's names here ☞

Mr. MONTGOMERY introduced the following bill; which was referred to the Committee on ____________

A BILL

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

That section 601(4)(C)(v) of title 38, United States Code, is amended by striking out ''September 30, 1982'' and inserting in lieu thereof ''September 30, 1983''.

BALTASAR CORRADA
RESIDENT COMMISSIONER, PUERTO RICO

KENNETH MARTY-LÓPEZ
ADMINISTRATIVE ASSISTANT

COMMITTEES:
EDUCATION AND LABOR
INTERIOR AND INSULAR AFFAIRS

Congress of the United States
House of Representatives
Washington, D.C. 20515

WASHINGTON OFFICE:
1410 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
AREA CODE: 202-225-2615

DISTRICT OFFICES:
DESETAU FEDERAL BUILDING
ROOM 229
CHARDÓN STREET
HATO REY, PUERTO RICO 00918
AREA CODE: 809-753-4240

P.O. BOX 128
PONCE, PUERTO RICO 00731
AREA CODE: 809-843-5840

TESTIMONY OF HON. BALTASAR CORRADA
OF PUERTO RICO

Before Subcommittee on Hospitals and Health Care
House Committee on Vetarans Affairs

March 17, 1982

My name is Baltasar Corrada, Resident Commissioner from Puerto Rico to the U.S. Congress. I have the privilege of being the sole representative of 3.2 million American citizens in that Island of which 165,000 are veterans.

I want to thank the members of this committee for giving me the opportunity to address the issue of medical assistance for veterans in Puerto Rico.

As a historical note I wish to point out that in March of 1917, as the First World War raged in Europe, Congress bestowed United States citizenship to the residents of Puerto Rico by enacting the Jones Act. During the First World War, 18,000 Puerto Ricans joined the Armed Forces and contributed to the United States victory in that conflict. I feel proud of our answer to the call of duty. We Puerto Ricans served without reluctance or reservation, we served gallantly and out of desire to prove our loyalty to the United States. As a matter of fact more than 270,000 Puerto Ricans have served in the Armed Forces since 1917.

Our human contribution to this Nation goes far beyond any commensurable amount. One thousand twenty five Puerto Ricans died and over 6,000 were wounded in U.S. wars. The deeds of

Puerto Ricans in defense of our ideals of democracy were highlighted during the Korean War where 700 Puerto Ricans died and over 2,000 others suffered casualties, a rate that would rank us third among all states and territories, in proportion to our population.

Mr. Chairman, it is a known fact that most veterans in Puerto Rico rely on the VA system for medical assistance and that their demand for care is higher than in any other place in the VA system. In the VA's "Report to Congress on Health Care for Veterans in Puerto Rico and the Virgin Islands," four valid reasons are provided to explain this situation: (1) the rates at which acute conditions occur are higher in Puerto Rico than in the United States mainland, indicating a somewhat poorer health status than for U.S. veterans in general; (2) mental health problems occur at a higher rate in the case of veterans in Puerto Rico than in the VA system as a whole; (3) the average Puerto Rican veteran cannot afford fee-for-service care; (4) the quantity of public health services provided by the Puerto Rican government are inadequate in relation to need. I may add that a major factor contributing to the last of these causes is that Medicaid applies in Puerto Rico on a very limited basis with the Federal government providing only $45 million while the Puerto Rican government provides over $120 million.

Thirty four percent of the veterans in Puerto Rico come from families with an income below $7,000; 42 percent from families with an income between $7,000 to $14,000 and only 24 percent come from families with incomes over $15,000. Even though the Puerto Rican government has annually increased its budget for health care services and facilities, inflation brought about an actual decrease in buying power. Puerto Rico's financial condition precludes a massive investment of funds in this area and therefore no major improvements in the health care system can be made on a short term basis. Currently, in the non VA sector of health care, there are fewer beds per 1,000 inhabitants in Puerto Rico than in the U. S. mainland. The quality of care provided and the adequacy of the medical facilities in Puerto Rico, even though significantly improved over the years, are still substantially below that provided at the Veterans Administration Medical Center.

Consequently, the VA Medical Center in San Juan has consistently received the largest number of applications for hospitalization in the entire VA system. It is ranked sixth in the Nation in number of staff visits and fourth in the number of medical visits. In FY 1981 this center attended 257,986 staff visits and 81,619 fee visits. The walk-in applicants in our VA Medical Center and the Mayaguez Clinic are over 300 a day. The VA Hospital in San Juan operates at full capacity with an occupancy rate of close to 90 percent throughout the year.

The high demand for medical assistance by veterans in Puerto Rico overwhelms the capabilities of the VA's limited facilities on the Island which also services the veterans of the Virgin

Islands. Contracting and fee for service have become the method for providing medical services to many veterans on these islands. The Contract Hospitalization Program in Puerto Rico and the Virgin Islands, which dates back to the Roosevelt Administration and was the only source of VA hospitalization until 1946, has been closely monitored over the years. In 1948 there were 32 private hospitals under contract with the VA in Puerto Rico which handled an average patient load of over 1,100 veterans. In recent years only seven hospitals remained under contract and the patient load had been reduced to 609. A new plan to further reduce the number of patients in contract hospitals has been in effect since the latter part of FY 1981. As of January 30, 1982, the average number of patients in the hospitals was down to 468. Let me point out that the patient reduction program is a result of budget constraints faced by the contracting-out program and not due to a decrease in the number of veterans in need for the health care services in Puerto Rico. This program received $1.1 million less for FY 82 than its allocation for FY 1981.

It is my understanding that the Veterans Administration, to avoid compromising in the quality of its health care services has forcefully increased the rejection rate of needy veterans on the Island.

The record shows that the VA has been highly selective in accepting applicants for medical assistance in Puerto Rico. For many years, the VA in Puerto Rico held the highest rejection rate in the system. Nevertheless, contracting-out medical services in Puerto Rico is still the only way for the VA, with its present facilities, to give adequate medical attention to all those veterans in need of care in Puerto Rico.

Mr. Chairman, I urge this Subcommittee to support the authorization to extend the flexibility granted to the VA to contract-out medical services for non-service-connected patients in Puerto Rico until a new program is implemented to take care of the needs of our veterans on the Island.

I believe time is ripe for us to consider the options presented by the Veterans Administration in its "Report to Congress" of how to solve the inadequacies of the VA system on the Island.

I particularly support the alternative of building a new wing in the VA Hospital Center in San Juan to house all VA's psychiatric patients and closing of all psychiatric beds in contract hospitals when the additional facilities are available. Mental illness is the number one health care problem in Puerto Rico. We have 8,108 veterans in Puerto Rico who have not been able to recover from the traumas caused by the horrors of war suffered at the expense of our security and freedom. There are also many more non-service-connected veterans with mental disorders lacking proper medical attention. Currently, the VA can only house 240 psychiatric patients and contracts out for an additional 564 veterans in facilities not comparable in quality of care to the VA's facilities. The average length of stay in the VA's facilities on the Island is 22 days whereas in contract hospitals it averages over 90 days.

The new wing will bring together the advanced services utilized by the VA's medical staff for efficiently handling psychiatric cases and adequate facilities to house these services. I am confident this arrangement will prove to be more efficient and less costly to the Administration and beneficial to our veterans.

I trust you will give this matter your thoughtful consideration and that you will support any measure directed to offer more adequate medical assistance to our veterans in Puerto Rico.

STATEMENT OF
DR. DONALD L. CUSTIS
CHIEF MEDICAL DIRECTOR
DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS' AFFAIRS COMMITTEE

MARCH 17, 1982

Mr. Chairman and members of the Committee:

I am pleased to be here this morning to testify on proposals to extend certain expiring authorizations and on a new initiative to authorize the Administrator to approve flexible hours or a compressed work schedule for VA-registered nurses.

Section one of H.R. 5737 would extend for three years the authorization for appropriations for grants to States for the construction, remodeling or renovation of State home facilities. As you know, Mr. Chairman, we testified last September before this Committee in support of H.R. 4025, an Administration proposal to extend for four years the authorization for appropriations for the State home construction program and to extend the reporting period for VA's drug and alcohol dependence contract program.

As we testified last September, we strongly support extension of the State home construction grant authority. We are submitting to the Speaker of the House today and offer for your favorable consideration, a new draft bill that incorporates the provisions of our earlier proposal as well as new initiatives to further strengthen the State home program.

We commend that proposal to you, Mr. Chairman, for your favorable consideration. Since we are unable to support aspects of H.R. 5737, we propose that you introduce and support our draft bill, the State Veterans' Home Amendments of 1982, as a substitute measure.

Although H.R. 5737 would extend the authority for the State home construction grant program, it would also extend other programs which we believe have largely accomplished their purposes. For example, section 2 of H.R. 5737 would extend for an additional three years the authorization for appropriations for exchange-of-medical-information grants. This is an authorization to fund pilot programs through grants to facilitate the exchange of medical information between VA facilities and other medical institutions. The program originated with Public Law 89-785, enacted in 1966. The exchange of medical information authority, of which grants are just a part, was intended to help cultivate an environment of academic medicine in VA hospitals, especially those in remote areas. The grants were to be used for such purposes as the employment of personnel, the construction of facilities, and the purchase of equipment to develop and carry out medical information programs.

In the past 15 years, 64 pilot projects have been funded. As projects have become operational, continuing support has been provided by other funding sources.

The Exchange of Medical Information program has been successful in the past in helping to create academic links between relatively remote VA hospitals and major medical centers. Now -- 15 years after its start -- the pilot grant program has essentially accomplished its purposes.

As I indicated, the expiration of this grant authority (under section 5055 of title 38) does not deprive the VA of the authority (under section 5054) to enter into agreements to share medical information. It should be understood that our exchange of medical information program to date has been geared almost exclusively to the establishment of grant-funded projects. Under section 5054, we have broad authority, separate and apart from the grant authoriztion, however, by which VA medical centers could initiate agreements locally to share educational and informational resources, just as we share specialized medical resources. There is an incentive to engage in such sharing because reimbursements are credited to the medical appropriation. Our challenge is to apply that authority and develop agreements for exchange of medical information services with the surrounding medical community where beneficial. This can be done without Federal grants.

H.R. 5737 would also extend for three years the authorization of appropriations for grants to VA-affiliated medical schools and other health manpower training institutions. This grant program was established pursuant to Public Law 92-541, the Veterans' Administration Medical School Assistance and Health Manpower Training Act of 1972. We view this program as having largely served its purpose. While the program has been beneficial, the need has diminished and additional funding cannot be reconciled with more pressing mandates. In essence our priority must be on providing quality medical care to eligible veterans.

Our draft bill, which reflects that priority, is aimed at extending and making improvements in the State home program. That program is a cost-effective approach to providing domiciliary, nursing home, and hospital care for older veterans. The amendments proposed in our draft bill would not only prevent the lapse of our authority to assist States through grants for construction of those facilities but would also authorize VA medical centers to share specialized medical resources on a reimbursable basis with these State facilities. This important initiative would give VA facilities specific authority to enter into agreements to provide State home patients with sophicated medical services through resources not used to optimum capacity. By this means we can help improve the quality of care in State veterans homes and make most efficient use of VA resources.

Contract Health Care in Puerto Rico

Mr. Chairman, you have introduced legislation to extend for one year the VA's specific contract authority to provide hospital and outpatient care for veterans in Puerto Rico and the Virgin Islands.

Currently, the VA has the authority in Puerto Rico and the Virgin Islands to provide, through contracts, or on a fee-for-service basis, hospital care and medical services (to obviate the need for hospital care) for the treatment of nonservice-connected disabilities of veterans. Provision of authorized care and services is conditioned on the requirement that the annually-determined patient load and the incidence of the provision of medical services for veterans hospitalized and treated by the VA under that authority be consistent with the level of care and service provided within the 48 contiguous States.

The Administrator is authorized to waive that limitation with respect to Puerto Rico and the Virgin Islands. Public Law 95-520 extended the authority to provide this care until

December 31, 1981, and also required that the VA conduct and submit to the Congress and the President a report assessing the health care needs of veterans in Puerto Rico and the Virgin Islands with recommendations on how these needs should be addressed. This report was submitted to the Congress on March 10, 1981.

In assessing veteran health care needs in Puerto Rico and the Virgin Islands, our report identified a series of problems unique to that locale. These included: (1) low quantity and quality of non-VA psychiatric care, (2) inadequate ambulatory care facilities, (3) near absence of nursing home beds, and (4) inaccessibility of health care outside the VA. It was also found that because of those unique problems, and because the ratio of service-connected to nonservice-connected veterans was higher in Puerto Rico and the Virgin Islands than in the United States, the rate of veteran utilization of VA care in those islands was greater. Our report ultimately did not make any final recommendation, but outlined instead a series of options for the Congress to consider. These specific options reflected the different means by which VA might provide veterans of these islands with hospital, nursing home, and outpatient care, respectively.

With less than a year remaining between the time our report was submitted and the expiration of the contract authority, Congress extended that authority until the end of fiscal year 1982.

We recognize that Congress may not have the time to evaluate this entire issue, including our report and recommendations. For these reasons, we consider it to be prudent that this authority be extended for an additional year rather than risk either the expiration of this authority without the provision of an alternative means of medical care for these veterans or the hasty enactment of legislation which might not be the most appropriate. We support this bill.

Extension of this authority until September 30, 1983, will result in an estimated cost to the VA of $8.87 million.

Flexible Hours/Compressed Work Schedules

The provisions of Public Law 96-330, the VA Health Care Amendments of 1980, have improved the Department of Medicine and Surgery's ability to recruit and retain Registered Nurses through the establishment and use of localized salary rates which are competitive with those paid by competing hospitals and health care facilities. The Department has currently authorized 65 facilities to pay above minimum salary step rates at one or more grade levels. It has also authorized an additional twenty-two facilities to establish special salary ranges at one or more grade levels which exceed the normal title 38 pay ranges. DM&S recently conducted a thorough review of its Registered Nurse Compensation plan. As a result, it is refining its pay setting practices so that VA facilities will be able to pay rates more closely matching community practices. These changes provide an improved basis for deriving basic pay comparability by weighting survey data for the size of the competing facility, the number of R.N.'s it employs, and the character of its patient mix. These refinements also allow the Department to compete with community practices on premium pay, overtime pay, and shift differentials.

These flexibilities, together with the changes occurring in the economy as a whole, have made the VA more attractive as an employer. Although a number of facilities continue to experience difficulty in recruiting and retaining R.N.'s, this is typically a function of difficulty in recruiting and retaining R.N.'s due to the local labor market not being sufficient to meet the requirements of the community in terms of the numbers of hospital beds operated. In those instances in which it was a simple case of the VA pay package not being competitive, adjustments have been made. The recruitment and retention situation in California, which had reached a critical stage, has been stabilized by using the flexibilities of Pub. L. 96-330.

Recently the rate at which VA facilities have been requesting increased salary schedules has declined. Many public and private facilities have reached at least a temporary limit to the level of salaries they pay to Registered Nurses. Competition is beginning to occur in non-monetary areas that improve the quality of both working and non-working life, and which make one employer more desirable than another. Fortunately, I believe that title 38 now contains sufficient authority for improving the quality of work in our VA facilities. Under section 4107(e)(5) the Department has established essentially a compressed workweek - for example, four consecutive days' work of ten hours per day instead of five days of eight hours - with the consent of the individual affected nurse. In addition, Pub. L. 95-390, expiring this month, was the basis used for experimental compressed work schedules at three locations within the Department. The positive experience in these experiments indicates that compressed workweeks have significant potential for mitigating recruitment and retention problems with nurses. The authority to install them thus complemented the special salary authority enacted in Pub. L. 96-330. We can, I believe, expect to see recruitment and retention figures improving as these dual authorities have their full effect on the system. The implementation of both authorities will be among the subjects of the study and reports called for under section 118 of that law.

As we accumulate experience with compressed workweeks established under section 4107, we will be better able to judge judge whether additional authority is needed to improve recruitment and to keep nursing staff at levels the VA must maintain.

The Department of Medicine and Surgery feels it is necessary to be competitive for it to recruit and retain Registered Nurses in order to maintain quality patient care. However, we do not believe that the need for legislation in this area has been clearly established. As previously mentioned there are other alternatives to consider to meet the competition for nurses in specific locations. We feel that the so called "Baylor Plan" workweek as well as other alternatives should be studied by our Nursing Task Force that was created to review nurse recruitment and retention problems as directed by section 118 of Pub. L. 96-330.

In summary, the VA is better able to effectively compete with other health care facilities for Registered Nurses on the basis of salary by exercising the flexibilities contained in Pub. L. 96-330. We recognize the challenge to be met concerning the use of alternative work schedules and compressed workweeks. We feel that it is necessary to meet community practices to compete effectively. However, we do not favor the enactment of a structured, defined program such as the Baylor Plan.

This concludes my statement, Mr. Chairman. I will be happy to answer any questions.

PVA
PARALYZED
VETERANS
OF
AMERICA
CHARTERED BY THE CONGRESS OF THE UNITED STATES

STATEMENT OF
GORDON H. MANSFIELD, ASSOCIATE LEGISLATIVE DIRECTOR
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
PROPOSED HEALTH CARE LEGISLATION
MARCH 17, 1982

Mr. Chairman and Members of the Subcommittee, it is a privilege for me to appear today on behalf of the members of Paralyzed Veterans of America. I sincerely appreciate the opportunity to express PVA's views and concerns regarding the proposed legislation.

This Subcommittee, like the full Committee, has always shown a desire to improve the quality of health-care services delivered by the Veterans Administration. PVA remains grateful for the effort and concern you continue to exhibit. The proposed legislation would extend the VA's exchange of medical information programs, its contract medical care in Puerto Rico and the Virgin Islands, the VA's grants to affiliated medical schools, and would provide for an amendment to Title 38,

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United States Code, to permit flexible hours or compressed work schedules for VA registered nurses. PVA believes that implementation of these legislative proposals will contribute to better health-care services for the Nation's veterans.

Mr. Chairman, PVA is especially supportive of legislation designed to assist in the recruitment and retention of qualified nursing personnel. The Chief Medical Director has reported that as of October, 1981 there existed a shortage of 1,200 RNs and 900 LPNs in the VA health-care system. If these shortages were spread over the entire VA system the impact on patient care would not be serious. However, when a large number of RN vacancies are concentrated in a few VA Medical Centers, the problem becomes critical. And, when these same VAMCs are also experiencing a significant number of LPN vacancies, nursing care and other services which nurses routinely provide to patients are seriously compromised. The resulting decline in patient care can be most serious to catastrophically disabled veterans such as SCI patients who require a continuous level of higher-degree nursing attention. The result is that fewer nurses administer to larger numbers of patients in the VA system. Further, many of those served are elderly, often with multiple body system failure, which requires more nursing time. Hours per patient day for nurse interaction with patients are disproportinately lower in the VA than in the private sector.

PVA understands that Ms. Vernice Ferguson, Associate Chief Medical Director of Nursing Programs, has been working on programs to increase recruitment and retention of nursing personnel for the VA health-care system. Ms. Ferguson has indicated that the VA historically was preeminent in the benefits offered its nurses. Waiting lists for nurse positions within the VA were common during the 1950's and 1960's. The VA salary schedule was generally higher than that offered in the private sector. It was recognized that the workload in VA hospitals, with fewer people to do the work, was accepted and offset by the good salary and fringe benefits. Benefits offered by the VA were health-care industry pace setters and included:

1. The accrual of sick and annual leave upon entering employment and a generous plan of days earned per year. (When the VA was offering 4 weeks of annual leave per year, many hospitals offered only 2 weeks).

2. A retirement system with eligibility for inclusion in the plan on employment. (In many institutions nurses were not eligible for inclusion until 3 to 5 years of employment had been completed).

3. The clinical ladder concept, with appropriate pay for remaining in patient care nursing positions.

The present market for nurses is much more competitive. Private sector hospitals offer equivalent or higher pay than does the VA. Also, a range of fringe benefits are offered. Among these benefits are free dental care, free hospitalization and medical care, free or reduced-price pharmaceuticals, tuition reimbursement, and paid days off to attend continuing education courses.

A recent phenomenon in nursing employment is the temporary employment agency which offers work for nurses while allowing them to set their own schedule. This alternative to traditional nurse recruitment offers an attractive option to those professionals who desire to arrange their daily or weekly work schedules around individual pursuits such as child rearing, school, or other personal goals.

The Chief Medical Director (CMD) and the Deputy Assistant Chief Medical Director for Nursing Programs are working to correct certain deficiencies the VA faces in the recruitment and retention of nursing personnel. PVA supports VA initiatives aimed at increasing the number and quality of RNs and LPNs through programs such as the compressed workweek. Experiments are being conducted under the Flexible and Compressed Work Schedules Act (Public Law 95-390) at three VA medical Centers - Ann Arbor, Wadsworth, and New Orleans. The results of this experimental program, which is due to end March 29, 1982, should receive careful scrutiny by this Committee and there should be appropriate legislative action. The VA indicates that as of August 1981, 165 VAMCs had indicated a desire for compressed work week schedules.

PVA is particularly concerned about the absence of funding in the Administration's FY'83 Budget for continuation of the VA program to provide for nursing scholarships. And, PVA hopes the Committee will work to rectify this situation. Other legislative action may also be required to implement nurse recruitment and retention programs within the VA health care system. PVA advocates providing the VA with up-to-date policies in this critical area.

Also, PVA believes that positions for RNs, LPNs, and other health care personnel should be upgraded for those who serve in SCI Centers. Patient care in SCI Centers is more intensive, time consuming, and rigorous, and the dedicated personnel who serve there should be compensated accordingly.

Turning to other health-care matters, PVA urges favorable consideration of the proposed legislation to extend for one year the authority for the provision of Veterans Administration health care by contract in the Commonwealth of Puerto Rico and in the Virgin Islands. Each of these locations has unique problems and situations which can best be answered by the extension of the authority for contract care. Puerto Rico and the Virgin Islands had a combined population of approximatley 3,500,000 in 1979. The estimated veteran population in 1979 was 169,000 for Puerto Rico and 5,000 for the Virgin Islands. These figures indicate the veteran population is approximatlely 5% of the total for each location.

The San Juan VAMC Primary Service Area (PSA) includes all of Puerto Rico and all of the Virgin Islands. During the period of 1975 to 1979 discharges of veterans living in the PSA rose from 8,470 to 10,623 patients. This is a faster growth rate than that of the veteran population during the same period. The VAMC occupancy rate remained above the 85% level which is the suggested VA standard for occupancy rates. In FY1979, the total number of discharges was 10,623, with 38% (4,084) in medicine, 33% (3,531) in surgery, and 29% (3,008) in psychiatry. There were 3,777 hospital inpatient discharges from VA contract care facilities in Puerto Rico and the Virgin Islands in FY1979. Of these contract discharges. 32% (1,206) were for medical discharges, 8% (298) were for surgical discharges, and 60% (2,273) were for psychiatric discharges.

In its "Report to Congress on Health Care for Veterans in Puerto Rico and the Virgin Islands," dated April 9, 1981, the VA indicates there are more VA medical, surgical, and psychiatric beds available per 1000 veterans in Puerto Rico and the Virgin Islands than in the United States. However, the reverse is true in the non-

VA sector, with fewer beds per 1000 inhabitants in Puerto Rico and the Virgin Islands than in the United States. This insufficiency in the non-VA sector, combined with the inability of many veterans to pay for care in the private sector, the inadequate quality and quantity of services in the public (Commonwealth) sector, and the veterans' desire not to use free care, severely limits alternatives to VA health care. Site visit reports and interviews conducted to gather data for the above mentioned "Report to Congress" determined that veterans believe that the care at the VAMC is the quality standard and the non-VA public government sector care is inadequate by comparison. Veterans feel the facilities and personnel in the Puerto Rico non-federal public sector are insufficient to meet workloads. And, the veteran feels he has earned the VA care because he served in the U.S. military and he disdains "free" care from the Puerto Rico non-federal public sector because he has done nothing to earn it. In short, PVA recognizes the unique and special circumstances which surround veterans health and medical care in Puerto Rico and the Virgin Islands, conditions which do not exist in the United States.

PVA believes that authority for contract services should be extended for at least one additional year. During this period the VA and the Congress may develop the anticipated plan for VA health-care delivery in Puerto Rico and the Virgin Islands without disrupting services which are currently utilized.

In a third area of consideration today, Mr. Chairman, PVA supports the passage of H.R. 5737, a bill to extend expiring authorities of the Veterans Administrations to make grants related to State nursing home facilities, exchange of medical information, and support of medical schools, which you have introduced. The extension of authority to make grants for State nursing homes provides for new construction and the expansion, remodelling, or alteration of existing buildings for furnishing domicilary, nursing home, or hospital care to veterans in State homes. PVA believes the extension of authority to provide grants is especially important at this time when the number of aging veterans is increasing. Also, the failure of the Administration to fund additional Geriatric Research, Education Clinical Centers for FY'83 indicates a need to continue other existing efforts to care for our Nation's older veterans.

The Exchange of Medical Information Program is designed to provide a professional environment of academic medicine to assist the VA health-care system in attracting and retaining highly trained and qualified members of the medical profession. The Administrator is authorized to enter into agreements with medical schools, hospitals, research centers, and individual members of the medical profession. The result of these agreements is the free exchange of medical information and techniques. PVA believes that this program is an especially important tool for retaining qualified medical professionals and is needed to offset the reduction of VA research funds requested in the last two fiscal years.

Finally, Mr. Chairman, PVA supports extension of authority to provide grants to medical schools. These grants to medical schools which are affiliated with the VA are designed to assist such schools to expand and improve their training capabilities. The provisions of Section 5083, Title 38, United States Code, require matching funds, fiscal contracts and accounting procedures, and reports to ensure the funds are well used. Also, PVA believes that the Congress has provided adequate legislation to ensure that the VA remains in control of patient care in those facilities where affiliation agreements exist.

Mr. Chairman, PVA supports all of the beneficial legislative proposals I have addressed. This concludes my statement and I will be happy to answer any questions that I can.

VFW VETERANS OF FOREIGN WARS OF THE UNITED STATES
NATIONAL LEGISLATIVE SERVICE
Office of Director

STATEMENT OF

JAMES N. MAGILL, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

WITH RESPECT TO PROGRAM EXTENSIONS

WASHINGTON, D. C. MARCH 17, 1982

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you Mr. Chairman for the opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to various program extensions and the authorization of flexible hours or a compressed work schedule for VA registered nurses.

It is our understanding legislation will be introduced to extend the authority of the Veterans Administration to enter into contract agreements to provide medical care to certain veterans in Puerto Rico and the Virgin Islands. As you know, when a VA health care facility is unable to provide needed medical care due to an inadequate facility or where there is no VA facility, authorization may be granted by the Administrator to enter into contracts with the private sector to provide such care. Such is the case in Puerto Rico and the Virgin Islands. Although there are more VA medical, surgical, and psychiatric beds available per 1,000 veterans in Puerto Rico and the Virgin Islands as compared to the United States, conditions in the private medical care sector in these two locations, by comparison, are dismal. With the inability of the private sector to meet the demands plac upon it by the general populace, a severe limitation is placed on alternatives to VA health care for veterans. Other factors contributing to the imbalance are the veterans inability to pay for private treatment, the veterans refusal to accept charity, and the questionable level of quality care available in the private sector. Where the situation is most acute is in the area of veterans with psychiatric conditions. Because of this, a major burden is being placed on the VA to treat veterans in Puerto and the Virgin Islands with psychiatric problems, resulting in the need to seek contract care.

The best information available to us indicates veterans in Puerto Rico and the Virgin Islands are suffering a much higher incidence of service-connected disability for psychiatric reasons than the veteran population as a whole. It has also been brought to our attention that the work load for processing these claims has reached such a level that some case files must be sent to the United States for adjudication, many times putting the veteran and/or the VA at a disadvantage.

Mr. Chairman, last year the VFW supported extending contract authority in Puerto Rico and the Virgin Islands until September 30, 1982. That extension was to enable this Subcommittee time to evaluate the VA's published report on the health care needs of veterans in this region. We believe that it is now time to fulfill the VA's commitment to our veterans of Puerto Rico and the Virgin Islands by expanding the psychiatric facility in Puerto Rico to provide the much needed VA care these United States citizens deserve. By expanding this facility, greater control over the level of care can be exerted, more complete and comprehensive psychiatric evaluations can be made, and the need to contract with the private sector eliminated. It should be understood the VFW is recommending the expansion of the psychiatric facility with the view that mental health care be supplied soley within the limits of the Veterans Administration, and contract authority be suspended when the facility is operational. We, therefore, support the extension of the contract authority but only under the limitations previously stated.

Mr. Chairman, HR 5737, introduced by you, extends for three years the exchange of medical information program and authority for the VA to make grants to affiliated medical schools. The VFW views these two programs as beneficial to the VA medical care system, and we support their extension for the three year period. In addition, the bill extends the autnority to make grants to State nursing home facilities, which, as you know, we supported in previous testimony before this Subcommittee.

Finally Mr. Chairman, it is also our understanding a bill will be introduced to provide flexible hours or a compressed work schedule for VA registered nurses. As you know, the VA has been experiencing a shortage of nurses for quite some time. In fact, because of this shortage, entire wards in some VA medical care facilities have been forced to close. In addition, nearly 800 beds in the VA medical care system have been eliminated for this same reason. The VA must remain as competitive as possible with the private sector regarding the nursing profession. The VFW believes the proposal to allow flex-time or a compressed work schedule may serve as a viable recruitment/retention tool. We support this proposal and encourage its implementation as long as the Administrator and the Chief Medical Director deem such a proposal will not be detrimental to providing high-quality health care to our Nation's veterans.

Mr. Chairman, again the VFW appreciates the opportunity to come before this distinguished Subcommittee to express our views.

This concludes my statement. I will be happy to respond to any questions you may have.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

on

HEARING ON EXTENSION OF EXCHANGE OF MEDICAL INFORMATION PROGRAM, CONTRACT MEDICAL CARE IN PURETO RICO AND VIRGIN ISLANDS AND VA GRANTS TO AFFILIATED MEDICAL SCHOOLS AND ON AN AMENDMENT TO TITLE 38 FOR FLEXIBLE HOURS OR A COMPRESSED WORK SCHEDULE FOR VA REGISTERED NURSES

MARCH 17, 1982

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
MARCH 17, 1982

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to appear before this Subcommittee to present its views on the several legislative proposals scheduled for your consideration today.

In general these measures would extend the authority of the Veterans Administration to make grants related to State Veterans Homes, for the exchange of medical information, and for the support of affiliated medical schools; to extend the authority for contract medical care in Puerto Rico and the Virgin Islands; and to authorize the Administrator of Veterans Affairs to approve flexible hours or a compressed work schedule for VA registered nurses.

Mr. Chairman, with your permission we will now address the legislation currently under consideration.

H.R. 5737

Section 1 of this measure would amend section 5033(a) of title 38, United States Code, by authorizing the appropriation of such sums as may be necessary for FY 1982 and for the three succeeding fiscal years for the purpose of making grants to States which have submitted, and have had approved by the Administrator, applications for such grants for the construction, remodeling and renovating of State Veterans Homes.

Under current law, there is authorized to be appropriated $15 million for the fiscal year ending September 30, 1978, a like sum for each of the two succeeding fiscal years, and such sums as may be necessary for the fiscal years ending September 30, 1981, and September 30, 1982.

Mr. Chairman, The American Legion recognizes the important role the State Veterans Homes assume in providing domiciliary, nursing home, and hospital care to disabled veterans, thereby reducing the burden that otherwise would have been placed on the Veterans Administration. When considering the present climate of fiscal austerity within the Federal Government the role of the State Homes becomes even more significant, and we applaud those individuals responsible for the administration and operation of the State facilities.

The American Legion is mandated by Resolution No. 9 (Vermont), approved by the Delegates to our 1980 National Convention, to support legislation to provide adequate funds for construction, remodeling and renovation of State Veterans Homes, and as a result thereof the Legion urges the approval of this provision of H.R. 5737.

Section 2 of this proposal would amend section 5055(c)(1) of the title by authorizing to be appropriated $4 million for Fiscal Year 1982 and such sums as may be necessary for the three succeeding fiscal years for the purpose of developing and carrying out medical information programs on a Pilot Program basis, and making grants to medical schools, hospitals and research centers to assist such facilities in planning and carrying out agreements with the Veterans Administration under which medical information and techniques will be freely exchanged.

The American Legion realizes the importance of the exchange of medical information between VA medical centers, major medical centers in the private sector, and other facilities within the medical community for the purpose of a continuing cooperative training and education program for health-care personnel. Therefore, the Legion supports the intent of this proposal.

Section 3 of H.R. 5737 would amend subsection (a) of section 5082 of the title by authorizing the appropriation of $30 million for Fiscal Year 1982 and such sums as may be necessary for the three succeeding fiscal years. The purpose of the appropriation is to provide grants by the Administrator of

Veterans Affairs for assistance in the establishment of State medical schools if such schools are located in proximity to and in conjunction with VA medical facilities. The grants are also provided to medical schools which have maintained affiliations with the Veterans Administration in order to assist such schools to expand and improve their training capacities, and to cooperate with certain other educational facilities for the training or education of allied health or other health personnel affiliated with the Veterans Administration for the conduct of or the providing of guidance for education and training programs for health manpower.

This is an extension of previous legislation for which we have expressed our support. The American Legion feels it is reasonable to extend the time for the accomplishment of the purposes set forth in Chapter 82 of the title.

The following two legislative proposals had not been introduced at the time this statement was prepared, therefore, they are not identified by bill number.

The first measure would amend section 601(4)(C)(v) of the title by providing an extension of the authority to provide contract hospital care and medical services in the Commonwealth of Puerto Rico and the Virgin Islands.

The Legion is in support of such an extension of authority as it would continue to provide medical services to veterans residing in these possessions of the United States.

Mr. Chairman, the next proposal would amend section 4107 of the title by authorizing the Administrator of Veterans Affairs to approve flexible hours or a compressed work schedule for nurses in VA medical care facilities.

The American Legion is very much aware of the critical nationwide shortage of nurses in public and private hospitals, and particularly in the VA medical care system, where the shortage in VA medical centers has led to the closure of beds and interference with the delivery of quality care to sick and disabled veterans.

The recruitment and retention of registered nurses in the VA has become increasingly difficult because levels of compensation have been inadequate in comparison with what is being offered in the private sector.

It was our hope that the enactment of PL 96-330, the Veterans Administration Health Care Amendments of 1980, would help improve the recruitment and retention of these health professionals. However, the Administration's proposed VA Budget for FY 1983 does not include funding for the nursing scholarship program established under this law.

As a result of the Legion's serious concern regarding the critical nursing shortage, the National Executive Committee, at its meeting of October 14, 1981, approved Resolution No. 17 (copy attached herewith), which urges VA to undertake a study to develop programs to attract registered nurses into VA service, and to present the results of the study to Congress with request for additional funds and for legislative authority to implement programs that will attract nurses into the service of the VA medical care program.

We are aware that the VA recruitment and retention efforts for nursing personnel have been intensified, and The American Legion is supportive of these positive undertakings. However, the fact remains that hospitals in the private sector enjoy a freedom from the limitations and restrictions that constrain the Veterans Administration's recruitment and retention activities, and therefore have a substantially greater capability in offering fringe benefits and other inducements to attract nurses.

The enactment of legislation to authorize the Administrator to provide flexible work schedules for VA nurses would significantly increase the Department of Medicine and Surgery's ability to compete with the private sector in attracting and retaining nurses. Therefore, The American Legion strongly urges this Subcommittee to give favorable consideration to this proposal. An exacting need for flexibility in providing fringe benefits within the nursing service has been demonstrated, and the Legion feels that the time to act is now.

Mr. Chairman, that concludes our statement.

SIXTY-SECOND ANNUAL NATIONAL CONVENTION OF THE AMERICAN LEGION
BOSTON, MASSACHUSETTS, AUGUST 19, 20, 21, 1980

RESOLUTION: No. 9 (Vermont)

COMMITTEE: Veterans Affairs and Rehabilitation

SUBJECT: Support legislation to provide adequate funds for construction, remodeling and renovation of State Veterans Homes

WHEREAS, there are 45 State Veterans Homes located in 33 States, dedicated to the long-term care of disabled veterans who served honorably in the United States Armed Forces; and

WHEREAS, the various States have cooperated with the Veterans Administration to provide a uniformally high level of long-term care for U.S. veterans in these State homes; and

WHEREAS, an increasing number of World War II veterans are 65 years of age and older, dramatically increasing the number of veterans needing nursing home care or extended medical care; and

WHEREAS, the United States Government has provided matching construction funds for the construction, improvement and remodeling of nursing care facilities in State Veterans Homes; and

WHEREAS, most planning for modernization and/or expansion in State Home projects is predicated on the availability of such matching funds; and

WHEREAS, any reduction of funds appropriated for these purposes will result in delaying or perhaps jeopardizing the construction of needed new modern facilities or remodeling of existing facilities for care of United States veterans; now, therefore, be it

RESOLVED, by The American Legion in National Convention assembled in Boston, Massachusetts, August 19, 20, 21, 1980, that The American Legion support legislation to provide that adequate funding be appropriated for the construction, remodeling and renovating of State Veterans Homes.

APPROVED WITH AMENDMENT

NATIONAL EXECUTIVE COMMITTEE MEETING
OF THE AMERICAN LEGION, OCTOBER 14-15, 1981

RESOLUTION NO: 17

COMMISSION: National Veterans Affairs and Rehabilitation

TITLE: Urging VA to Undertake a Study to Develop Programs to Attract Registered Nurses into VA Service

WHEREAS, There is an acute national shortage of registered nurses; and

WHEREAS, This shortage is causing serious problems in public and private sector hospitals everywhere; and

WHEREAS, The national shortage of registered nurses has resulted in severe nursing shortages in all VA medical facilities; and

WHEREAS, These nursing shortages in VA medical facilities are causing closure of beds and are interfering with delivery of quality care to sick and disabled veterans; and

WHEREAS, Hospitals and medical facilities throughout the country are undertaking a variety of programs to create greater interest in the nursing profession and to encourage nurses to remain active in their profession; and

WHEREAS, VA does not and has not devised a variety of incentives, including increased compensation, fringe and special benefits, and other inducements to attract nurses into VA service; and

WHEREAS, This failure by VA is placing it at a great disadvantage in competing with the private sector for nurses, now, therefore, be it

RESOLVED, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana on October 14-15, 1981, That The American Legion urges VA to immediately undertake a study into the need for establishing innovative and stimulating programs, scholarships, incentive pay and benefits that would attract nurses into VA service, and be it further

RESOLVED, That the results of the study be presented to Congress with request for additional funds and for legislative authority to implement programs that will attract nurses into the service of the VA medical care program for veterans.

DAV

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

March 17, 1982

Honorable Ronald M. Mottl, Chairman
Subcommittee on Hospitals & Health Care
House Veterans Affairs Committee
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Mottl:

This is in reference to your letter dated March 2, 1982, wherein you invite the opinion of the Disabled American Veterans with regard to certain legislation presently being considered by the Subcommittee on Hospitals and Health Care of the House Veterans Affairs Committee.

With respect to H.R. 5737, a bill that would extend by three years the current authority of the Veterans Administration to make grants related to state nursing home facilities, exchanges of medical information and support of affiliated medical schools, may I say that the DAV does favor Congressional passage.

Similarly, we support the extension of VA medical care contract authority in Puerto Rico and the Virgin Islands for an additional one year period.

We also strongly support amendment of current law (Section 4107, Title 38, USC) in order to provide that VA nurses who work two 12 hour regularly scheduled tours of duty over a weekend shall be considered to have worked a full basic work week.

We view the authorization of a "compressed work schedule" for VA nurses as a justifiable emulation of a commonly accepted policy that exists elsewhere in the medical community. It will, we believe, positively affect VA's ability to compete for the hiring and retention of nurses in its system vis-a-vis the private medical sector.

We therefore urge the Subcommittee to act favorably on the above cited legislation and request that our views, as contained in this letter, be included in the official Hearing Record.

Sincerely yours,

JOHN F. HEILMAN
National Legislative Director

JFH:ah

STATEMENT
BY
CONGRESSMAN RON DE LUGO, U. S. VIRGIN ISLANDS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS

MARCH 17, 1982

MR. CHAIRMAN, I WOULD LIKE TO THANK YOU AND THE MEMBERS OF YOUR COMMITTEE FOR THIS OPPORTUNITY TO TESTIFY ON THE PROPOSED EXTENSION OF THE VETERANS ADMINISTRATION'S AUTHORITY TO PROVIDE CONTRACT MEDICAL CARE IN PUERTO RICO AND THE U. S. VIRGIN ISLANDS.

I MUST FULLY SUPPORT THE EXTENSION FOR I HAVE NO OTHER CHOICE. LET ME EXPLAIN THAT STATEMENT.

PUBLIC LAW 95-520 OF OCTOBER 26, 1978, AUTHORIZED THE VA TO CONTINUE TO RELY ON PRIVATE SECTOR CARE UNTIL DECEMBER 31, 1981 TO MEET THE HEALTH CARE NEEDS OF VETERANS IN PUERTO RICO AND THE U. S. VIRGIN ISLANDS. AT THAT SAME TIME, THE CONGRESS DIRECTED THE VA TO STUDY THE HEALTH CARE NEEDS OF VETERANS IN PUERTO RICO AND THE U. S. VIRGIN ISLANDS. THAT REPORT WAS DUE ON FEBRUARY 1, 1980, BUT DEFERRED FOR ONE YEAR BY PUBLIC LAW 96-330. THE STUDY WAS FINALLY COMPLETED AND FORWARDED TO THE CONGRESS ON MARCH 10, 1981.

IN BRIEF, THE STUDY DOCUMENTS THAT, AND I QUOTE, ". . . A

SOMEWHAT WORSE STATE OF HEALTH OF THE PEOPLE OF PR/VI THAN OF THE U. S. AS A WHOLE, A LIMITED AVAILABILITY OF ALTERNATIVE MEDICAL CARE RESOURCES APART FROM THE VA, A GREATER PROPORTION OF SERVICE-CONNECTED DISABILITIES AMONG THE VETERANS OF PR/VI THAN AMONG ALL U. S. VETERANS, AND A DIFFICULT ECONOMIC STATUS BOTH FOR THE INDIVIDUAL PR/VI VETERAN." THE REPORT IDENTIFIES AS THE MAJOR PROBLEM AREAS, WHICH NECESSITATE THE EXTENSION OF CONTRACT MEDICAL CARE AUTHORITY IN PUERTO RICO AND THE U. S. VIRGIN ISLANDS AS:

LOW QUANTITY AND QUALITY OF NON-VA PSYCHIATRIC CARE;
INADEQUATE AMBULATORY CARE FACILITIES;
NEAR ABSENCE OF NURSING HOME BEDS;
INACCESSIBILITY OF HEALTH CARE OUTSIDE THE VA; AND,
ISOLATION OF VIRGIN ISLANDERS.

THE LAST PHRASE, MR. CHAIRMAN, ONLY HINTS AT THE PROBLEMS ENCOUNTERED BY U. S. VIRGIN ISLANDS VETERANS. I AM DISAPPOINTED THAT THE REPORT GLANCES OVER THE PROBLEMS OF OUR VETERANS IN THE U. S. VIRGIN ISLANDS. DESPITE THE FACT THAT THE CONGRESSIONAL MANDATE STIPULATED AN ANALYSIS OF ECONOMIC FACTORS IN BOTH TERRITORIES, THE ECONOMY OF PUERTO RICO WAS ANALYZED EXTENSIVELY, BUT THE ECONOMY OF THE U. S. VIRGIN ISLANDS RECEIVED NOT EVEN A FOOTNOTE. WE DID RECEIVE ONE FOOTNOTE , ON PAGE 16 OF THE STUDY, WHICH STATES THAT "BECAUSE THE RECORDS CONCERNING CONTRACT CARE AND FEE-BASIS CARE ARE NOT PROCESSED BY PATIENT ORIGIN, THE VIRGIN ISLANDS INFORMATION CANNOT BE EXTRACTED FROM THE PUERTO RICAN INFORMATION."

WHAT THIS MEANS, MR. CHAIRMAN, IS THAT SPECIFICS ON U. S. VIRGIN ISLANDS VETERANS WERE NOT EXTRAPOLATED; THE PROBLEMS ARE

NOT ANALYZED. WE SEE ALLUSIONS IN THE REPORT OF HOW MUCH GRAVER ARE THEIR PROBLEMS, HOW THE NUMBER OF DOCTORS, HOSPTIAL BEDS, NURSES, AND DENTISTS ARE LOWER PER POPULATION RATIO IN THE U. S. VIRGIN ISLANDS. FINALLY, ON PAGE 32 OF THE REPORT, THERE ARE THREE SENTENCES THAT GIVE A LITTLE PICTURE, ALBEIT UNDERSTATED, OF CONDITIONS FACED BY VETERANS IN THE U. S. VIRGIN ISLANDS. THE STUDY STATES:

> "ALTHOUGH THERE ARE THREE VA OUTPATIENT CLINICS IN PUERTO RICO, THERE IS NO VA PRESENCE IN THE VIRGIN ISLANDS. VETERANS IN THE VIRGIN ISLANDS MUST RELY ON THE FEE BASIS METHOD TO RECEIVE CARE UNDER VA AUSPICES. IF A LOCAL PHYSICIAN OR FACILITY IS NOT CAPABLE OF PROVIDING ADEQUATE TREATMENT FOR THE VETERAN, OR IF HE PREFERS VA STAFF CARE, HE TRAVELS TO THE SAN JUAN VAMC FOR TREATMENT."

THE PHRASE "HE TRAVELS TO SAN JUAN" MAKES IT SOUND SIMPLE AND EASY, BUT THIS IS HARDLY THE CASE. LONG DISTANCE PHONE CALLS MUST BE MADE; TRAVEL PLANS ARRANGED; VOUCHERS APPROVED, AND IN MANY CASES, DISAPPROVED; TRANSPORTATION MUST BE ARRANGED TO AND FROM AIRPORTS; AMBULANCES - AND ONLY PRIVATE ONES AT THAT - MUST BE COORDINATED IN ADVANCE. ADDITIONALLY, THE U. S. VIRGIN ISLANDS VETERAN, ONCE FINALLY ARRIVED AT THE VA CENTER IN PUERTO RICO, ENCOUNTERS LANGUAGE AND CULTURAL PROBLEMS. LOGISITICS AND COMMUNICATION ADD A BURDENSOME DIMENSION TO THE PROBLEMS FOR THE U. S. VIRGIN ISLANDS VETERAN THAT VETERANS IN PUERTO RICO AND THE MAINLAND DO NOT HAVE TO DEAL WITH.

THE STUDY, MR. CHAIRMAN, CONCLUDES WITH FOUR OPTIONS FOR INPATIENT CARE; SIX OPTIONS FOR OUTPATIENT CARE AND FIVE OPTIONS FOR NURSING HOME CARE, FOR WHICH THERE ARE NOW NO VA FACILITIES AT ALL IN EITHER PUERTO RICO OR THE U. S. VIRGIN ISLANDS. OF THE TEN OPTIONS FOR INPATIENT AND OUTPATIENT CARE, THE STUDY STATES THAT FOUR WOULD CONTINUE THE NSC ELIGIBILITY INEQUITY BETWEEN VETERANS RESIDING IN THE UNITED STATES AND VETERANS IN PUERTO RICO AND THE U. S. VIRGIN ISLANDS; TWO WOULD FURTHER EXACERBATE THE INEQUITY; TWO WOULD DECREASE SERVICE LEVELS FOR NON-SERVICE CONNECTED VETERANS; AND, TWO WOULD RATION VA HEALTH CARE TO BOTH SERVICE AND NON-SERVICE CONNECTED VETERANS AND, AS THE STUDY PUTS ITS, "CREATE DISSATISFACTION WITH THE VA AND THE U. S. GOVERNMENT ON THE PART OF THE VETERAN, VETERAN SERVICE ORGANIZATIONS, AND THE PUERTO RICO AND VIRGIN ISLANDS GOVERNMENTS."

THIS SUMMARY IS TELLING EVIDENCE OF THE ATTITUDE OF INDIFFERENCE TOWARD VETERANS IN THE U. S. VIRGIN ISLANDS.

SO, GIVEN THE CURRENT STATE OF AFFAIRS, AND GIVEN THOSE OPTIONS CONTAINED IN THE REPORT, I SAY, MR. CHAIRMAN, I DO SUPPORT EXTENSION OF THE VA'S AUTHORITY TO PROVIDE MEDICAL CARE IN PUERTO RICO AND THE U. S. VIRGIN ISLANDS. I HAVE NO OTHER CHOICE.

THE VA DOES, HOWEVER, HAVE THE CHOICE TO AT LEAST IMPROVE ON THE SITUATION IN THE U. S. VIRGIN ISLANDS. ON PAGE 38, THE REPORT STATES THAT SATELLITE OUTPATIENT CLINICS ARE GENERALLY RESTRICTED TO STANDARD METROPOLITAN STATISTICAL AREAS OF 150,000 OR MORE INHABITANTS, AND SETTINGS AT LEAST 40 MILES FROM ANY EXISTING VA

HEALTH CARE FACILITY. OPTION 2 OF OUTPATIENT OPTIONS RAISES THE POSSIBILITY OF A VA PRESENCE IN THE U. S. VIRGIN ISLANDS THROUGH A CONTRACT CLINIC OR A VA-OPERATED OUTPATIENT FACILITY ON BOTH ST. THOMAS AND ST. CROIX. THERE IS NO QUESTION THAT THIS IS THE MINIMUM THAT SHOULD BE DONE.

OUR POPULATION AND DISTANCE FROM PUERTO RICO WARRANT SUCH FACILITIES BY THE VA'S OWN GUIDELINES. FOR INPATIENT CARE, I WOULD SUGGEST A VERY LOGICAL AND EASY SOLUTION TO THE PROBLEM, WHICH FRANKLY, I AM SURPRISED WAS NOT PROPOSED IN THE STUDY. THE POSITION OF MEDICAL CARE OMBUDSMAN SHOULD BE ESTABLISHED WITHIN THE MEDICAL FACILITY IN PUERTO RICO AND STAFFED BY A VIRGIN ISLANDER TO COORDINATE THE ARRANGEMENT OF APPOINTMENTS, LOGISTICS, AND COMMUNICATIONS BETWEEN THAT FACILITY AND VETERANS IN THE U. S. VIRGIN ISLANDS. A SIMILAR POSITION SHOULD BE ESTABLISHED WITHIN THE OUTPATIENT CARE FACILITIES THAT SHOULD BE CREATED IN THE U. S. VIRGIN ISLANDS AS STATED ABOVE. THESE PROPOSALS COMBINED WOULD ULTIMATELY LOWER COSTS FOR THE VA IN THE LONG RUN. AND IN THE SHORT, LONG, OR ANY RUN THE VA BY SO DOING WOULD HONOR ITS OBLIGATION TO THE TOO-LONG NEGLECTED VIRGIN ISLANDS VETERAN. THE MEN AND WOMEN OF THE U. S. VIRGIN ISLANDS HAVE SERVED THEIR TIME AND DONE THEIR DUTY THE EQUAL, IF NOT MORE IN MANY CASES THAN THEIR COLLEAGUE VETERANS IN PUERTO RICO AND THE MAINLAND. THE DESERVE, IN FACT, IT IS THEIR RIGHT TO HAVE EQUAL TREATMENT AND EQUAL BENEFITS.

I WOULD URGE, MR. CHAIRMAN, THAT THE EXTENSION OF CONTRACT MEDICAL CARE BE EXTENDED, AND AT THE SAME TIME, THAT THE VA BE REQUIRED TO ESTABLISH AN OUTPATIENT CLINIC IN ST. THOMAS AND ONE IN

ST. CROIX WITH AN OMBUDSMAN IN EACH DISTRICT AND IN SAN JUAN FOR INPATIENT SERVICES.

THANK YOU, MR. CHAIRMAN, FOR THIS OPPORTUNITY TO BRING THIS TO THE ATTENTION OF YOUR COMMITTEE.

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